Decision Support Tools in Human Services Executive Summary
Community Human Services

Every person has value and deserves a place to call home. Community Human Services (CHS) honors these values by providing diverse, high quality services that ensure every person can live in stable housing. CHS brings 30 years of experience in preventing and stabilizing housing crises. That experience has led the agency to see that every day counts in resolving a crisis, yet even highly skilled intake coordinators need better coordinated assessment tools to make timely, data-driven decisions on the interventions that will be most effective to prevent or resolve a housing crisis. CHS plans to improve its homeless assistance programs by restructuring its intake process, and the agency requests $50,000 in financial support to finalize, implement and evaluate decision-support tools. As a leader in human services, CHS seeks to partner with DHS to pilot this coordinated assessment process that can be replicated throughout Allegheny County to improve efficiency and effectiveness in stabilizing housing crises.

The new intake system will allow individuals and families experiencing homelessness or in a housing crisis to meet with a trained staff member in person to expedite resolving the crisis or finding permanent housing. Intake coordinators will use the CHS Coordinated Assessment, a tool that simultaneously combines national best practices and proven research tools while asking only the questions necessary to determine eligibility. The tool has a clear scoring system making determinations for prevention/diversion, rapid re-housing/shelter, and permanent supportive housing standardized throughout the intake system while enabling staff to use their professional expertise to uses the nuances of each situation to make a determination. These tools will be integrated with the agency's centralized intake form and consumer database for long-term data tracking and easy cross-program referrals. The Service Prioritization Assessment Decision Tool (SPDAT), an internationally recognized case management tool, will assist caseworkers throughout CHS homeless assistance programs to tailor their work with each participant based on quantifiable data about individual situations, experiences and resources.

Development and implementation of these tools will be led by the agency's Director of Customer Service and Intake, and they will be integrated into the agency's database systems by the Chief Technology Officer. Continuous evaluation will occur over five years emphasizing both the implementation process and the quality of data collected. Qualitative evaluations of intake staff as well as annual consumer surveys allow CHS to improve both the staff and consumer experience. Quantitative data analysis will highlight successes and areas for continued improvement in data collection. By focusing on the two components concurrently, CHS will develop a system that seeks to use data and decision-support tools to support individuals and families experiencing homelessness and in crisis to find permanent and stable housing. CHS' organizational history, values, diverse service portfolio, community partners, and current infrastructure uniquely prepare the agency to partner with DHS to finalize, implement, and evaluate a new intake and coordinated assessment process.

Decision Support Tools in Human Services Proposal Narrative
Community Human Services

Organizational Background and Qualifications

CHS was founded on the core belief that every person has value, and every person deserves a place to call home. CHS honors this value by empowering those they serve and ensuring every person can live in stable housing, connect to community supports, build relationships and access quality food. As a non-profit social service provider, the agency brings 40 years of experience delivering the highest quality services to meet diverse needs: from basic needs of health, housing, and food to creating community spaces where all feel safe, welcome, and that they belong. Participants in CHS programs are successful because they receive proven services that take a holistic approach to make sure that each person can be healthy, happy, and safe in their home. The agency's expertise in service delivery, use of data to predict and measure success, and information technology infrastructure both enable CHS to be successful in serving individuals and families and make CHS a unique partner for the Department of Human Services in creating new decision support tools and predictive analytics.

Human Service Qualifications

People do best when they have a stable home in a community where they belong. CHS makes that possible for more than 5,000 people each year in Allegheny County by providing a network of human service programs that work synergistically to meet multiple needs, from food and housing to healthcare and community building. Diverse and holistic programs work together to address the entire hierarchy of human needs:

- The Residential Programs provide community-based supported housing and services designed to meet the individual needs, abilities, and goals of adults living with mental and physical health challenges.
    - Domiciliary Care: 18 individuals
    - Enhanced Supported Housing: 9 individuals
    - Supported Housing: 45 individuals
- The Homeless Assistance Programs empower individuals and families experiencing housing crises to obtain the resources and support to prevent homelessness and achieve and maintain independent living.
    - Eviction Prevention, Crisis Intervention, and Utility or Rental Assistance: 625 households
    - Atypical Shelter: 12 individuals
    - Permanent Housing through the Supportive Outreach Team: 75 households
    - Permanent Housing at Wood Street Commons: 43 individuals
    - Wood Street Shelter: 187 individuals

- The Health Programs provide quality health care for individuals who are uninsured or underinsured, including personal care and in-home help for individuals with disabilities to enable them to continue living independently in their own homes.
    - In-Home Services: 115 individuals
- Family Foundations Early Head Start provides early, continuous, intensive, and comprehensive child development and family support services to families with children from birth to age three.
    - Family Foundations Hill District: 41 families
    - Family Foundations North Side: 45 families
- The Community Programs provide a diverse mix of social gathering spaces, a community café, a social enterprise catering service, an open computer lab, physical wellness activities, and the Oakland Community Pantry.
    - Oakland Community Pantry: 1,157 individuals in November 2013, which represents a growth of greater than 144% over the prior 12 months
    - Bite Cafe: 12,614 meals served

All numbers above represent totals served by program for FY 2012-2013 except where indicated. Please note that these totals do not include the hundreds reached through street outreach, health clinics, and other informal programming. To deliver these excellent services, the agency has a staff of 110 from diverse backgrounds, including nine Masters-level social workers and three registered nurses. These programs are led by award-winning staff. The Director of Homeless Assistance Programs, Mac McMahon, was recognized with the 2011 Housing Heroes Award by the Housing Alliance of Pennsylvania for his tireless advocacy for individuals and families in housing crises. Director of Therapeutic Services Rebecca Labovick, RN, received the 2013 Outstanding Service Award from the National Health Care for the Homeless Council for her clinical services.

The excellence of these services is supported by a talented, award-winning administrative team and a respectful workplace culture that values each person. The agency was a 2013 finalist for the Forbes Funds' Wishart Award, a bi-annual award recognizing agency leadership, planning, evaluation, process improvement, and collaboration, as well as a repeat winner of the Post-Gazette's Top Workplaces award. For its direct service delivery, CHS has been repeatedly named an Organization of Excellence by the United Way of Allegheny County.

Research, Modeling, and Evaluation Expertise

CHS' core values are respect, relevance, quality and advocacy. Across all agency programs, from housing to food services to early childhood support, these values are shown daily by a commitment to providing the highest quality, most impactful services that are relevant and responsive to the people served.

CHS maintains ongoing committees for each of the core values to integrate them into daily activities. These committees are purely voluntary and managed by staff from all program areas who are passionate about the topics, going beyond the commitments of their existing positions. By creating focused groups dedicated to quality assurance and relevance, CHS incorporates the findings of research and evaluation projects into program design and day-to-day service

delivery. By including front-line staff from across the agency, these committees also serve to build a culture that values data-driven decision making, evaluation, and the best quality outcomes in a way that is not possible with just a dedicated evaluation staff position.

This data takes the form of both ongoing evaluation and outcome tracking across all agency programs as well as focused research projects on topics of interest. For example, in 2010 the agency undertook a community-based participatory research (CBPR) project utilizing the photovoice methodology to better understand the lived experiences of men and women experiencing housing crises. The project revealed strengths and weaknesses of the existing network of service providers, the social support and environmental factors that help or hinder an individual's progress toward their goals, and the deeply traumatic components of the crisis experience. Based on these findings, CHS has continued to focus its programs on early intervention and prevention and instituted a series of trainings for all staff on trauma-informed care. CHS has worked with DHS to share these findings with other providers and inform the way that services are delivered across the Continuum of Care.

On an ongoing basis, all CHS programs work closely with the agency's Quality Committee to evaluate their impact and continuously improve their services to best support program participants. For example, the CHS In-Home Services program exists to support adults living with disabilities to live independently in their own homes through personal care, household activities, and building natural supportive relationships. While CHS and other providers historically focused on participants with physical challenges, five years ago the ongoing assessment of participants revealed that many also experience mental health challenges. Outcomes data indicated that traditional in-home services were less successful for participants with both physical and mental health challenges.

In response, CHS partnered with the University of Pittsburgh to bring focused training on mental health best practices to all program staff and revised its assessment process to focus more carefully on mental health indicators. As a result, more than 98% of participants remained in their own homes safely and independently in the last 6-month reporting period. By building these new resources in response to actual program data, the agency has become a leader among its peers and receives regular referrals from other providers that are unable to support people with complex physical and mental health needs. These referrals currently make up more than 44% of all of CHS' In-Home Services participants, and their success in the program is reflected in that 98% figure above. As a result, the agency was awarded an additional contract from the Area Agency on Aging in 2012 to expand these services to seniors with disabilities that other providers are unsuccessful in serving.

Likewise, the CHS Oakland Community Food Pantry was started in 2009 in response to a gap in services in the community. By utilizing data on participant usage, family size, and referral sources, the agency was able to use regression analysis and mathematical modeling to accurately predict pantry growth and respond to increased demand. CHS focused on delivering excellent, culturally-competent, and responsive customer service by incorporating qualitative information on the increase in families who recently immigrated to the United States with unique cultural and dietary needs. As a result of these projections and an ability to focus on

excellent customer service, CHS has been able to fundraise for and expand pantry operations to keep pace with a 144% annual growth rate. Now, the pantry consistently serves more than 1,100 individuals each month and is the second largest in Allegheny County. This data-driven decision-making takes place across all CHS programs, leading to the success of both the agency and the people it serves.

CHS' publication history shows its capacity for evaluation and research. CHS staff members, including CEO Adrienne Walnoha, have co-authored with community and university partners on the following peer-reviewed publications, with an additional manuscript currently under peer review:

- Burke, J. G., Hess, S., Hoffmann, K., Guizzetti, L., Loy, E., Gielen, A., Bailey, M., Walnoha, A., Barbee, G. & Yonas, M. (2013). Translating Community-Based Participatory Research Principles Into Practice. *Progress in Community Health Partnerships: Research, Education, and Action* 7(2), 115-122. The Johns Hopkins University Press.
- Soska T. & Walnoha, A. (2012). Housing and Homelessness. *Social Work Matters: The Power of Linking Policy and Practice.* Washington, DC: NASW Press.
- Walnoha, A., Barbee, G., Burke, J., Hoffmann, K., & Yonas, M. (2012). Creating Synergies: Partnerships for Participatory Evaluation in Human Services. *Community Development in the Steel City.* Edinburgh: Community Development Journal Ltd.
- Dobransky-Fasiska, D., Nowalk, M. P., Pincus, H. A., Castillo, E., Lee, B. E., Walnoha, A. L., Reynolds, C. F., & Brown, C. (2010). Public-Academic Partnerships: Improving Depression Care for Disadvantaged Adults by Partnering With Non-Mental Health Agencies. *Psychiatric Services* 61(2), 110-112. American Psychiatric Association.

Information Technology Infrastructure

CHS has a strong internal capacity for building and implementing database tools to support effective direct service work and therefore can make data-driven decisions. Among social service providers, CHS is a leader in information technology capacity, having first implemented electronic data tracking systems in the 1990s to ensure quality records could be collected, maintained, and used to make informed decisions. The agency has a two-person dedicated IT team led by Paul Mosey, the CHS Chief Technology Officer. With nearly twenty years at CHS, Mr. Mosey has led the agency from the initial adoption of electronic records, databases, and email to managing a network for 110 staff across 7 geographic locations. Other organizations look to CHS for support and guidance because of its success at providing user-friendly technology solutions. The agency currently manages the IT infrastructure on a contracted, fee-for-service basis for two other area non-profit organizations. This infrastructure supports the effective delivery of diverse services, from supported housing to in-home supports for seniors to early child development programs. By providing these services, CHS is supporting more effective use of technology across social service systems while generating revenue to build and enhance internal technology capacity.

The success of this infrastructure is due to the ongoing flexibility and capacity of staff to create new solutions as the agency has grown. CHS has more than doubled in budget and staff over

the past ten years. As part of this growth, the agency has developed and expanded into new program areas to meet consumer needs. However, each of these program areas comes with different funders, different outcome tracking requirements, and even different consumer demographics. To improve efficiency, CHS has developed and is piloting a centralized intake form and database that can be used across all agency programs to collect all of the appropriate data to meet all funder requirements – and improve the ability of the agency to respond to predictive data along the way. Even more, this new system will streamline the delivery of services, making it easier for a family presenting at one CHS site to be quickly connected with multiple services – such as food, healthcare, housing, and early childhood support – through a single point of entry with no wrong door.

The complexity of CHS services made off-the-shelf data systems inappropriate, and a custom-built system was cost prohibitive. CHS staff, led by Mr. Mosey, researched and identified an open-source database platform called CiviCRM as the best solution for the database. The use of open-source software both reduces costs and enables system customization for the agency's uses. It also offers opportunities to build in multiple layers of data security to ensure HIPAA compliance and the protection of the people CHS serves. However, this flexibility requires staff expertise to appropriately build and implement.

CHS, and Mr. Mosey, are uniquely positioned to build such systems by bringing database, server, and network management experience. Mr. Mosey led the agency in transitioning its donor and volunteer database to a CiviCRM-based platform in summer 2013. This improved database is associated with an increase in individual giving year-over-year of more than 50% through careful targeting and segmenting of communications along with significantly reduced development staff time. CHS expects similar efficiencies through the consumer database and intake platform. Just as donors can be targeted based on demographics or past activity, program staff can quickly and easily refer participants for additional appropriate services. This new database and intake platform is in the final stages of development and is currently being piloted by a select group of staff around the agency.

This platform, and information technology expertise, forms the infrastructure for the assessment and decision-support tools proposed here. CHS' experience and history with effective data systems that are informed by and responsive to actual service delivery and consumer experiences positions the agency to be a successful partner with DHS in developing and implementing these tools.

History of Collaboration

Over the past 40 years, CHS has succeeded in supporting the health and wellness of diverse people by strategically collaborating with partners to bring specific expertise to have the greatest impact. These relationships range from other social service providers to academics and government agencies, each bringing specific strengths together to be the most successful.

Service Providers

CHS works closely with other providers to expand geographic reach and bring special skills and strengths to best serve people facing difficult and complex situations. The agency seeks these

relationships based on actual data on demand for services while incorporating best practices from research. For example, following the recession, CHS received a dramatic increase in calls from people facing eviction due to falling behind on rent. In response, the agency worked with North Hills Community Outreach (NHCO) and the United Way of Allegheny County to form the Home Matters Coalition. This collaborative effort utilizes the United Way's existing 2-1-1 telephone resource to quickly connect people with rent and utility assistance through NHCO and CHS, depending on geographic appropriateness. CHS augments these crisis prevention efforts by collaborating with NeighborWorks of Western Pennsylvania and PNC Bank to provide financial counseling and financial literacy classes to ensure lasting stability and the Squirrel Hill Health Center to provide primary healthcare to people who are uninsured or underinsured. These resources are made possibly by closely collaborating with Oakland Planning and Development Corporation through the Neighborhood Partnership Program to make community-based supportive services available, achieving an objective of the Oakland 2025 community plan.

Housing is at the core of CHS' services because it serves as a foundation for health, wellness, and success. CHS has sought out strategic partnerships with healthcare providers to build from that foundation with comprehensive health care support. For example, the Cultivating Health for Success program is the product of work with UPMC Health Plan and Metro Family Practice. By playing to each partner's strengths, the collaboration provides stable permanent housing from CHS, health insurance, and primary care to individuals who have experienced homelessness, have a disability, and have a history of repeated inpatient and emergency department stays. As a result, the collaboration has seen participants successfully stabilize their housing, shift their health care access from emergency rooms to primary care, improve their chronic health conditions, and reduce costs to the health system by more than 6% year over year.

These collaboration projects are particularly effective because CHS is an active leader within local networks of providers. As part of the Allegheny County Continuum of Care, CHS Homeless Assistance Programs provide a range of supports from prevention to street outreach to permanent housing. By working with the Department of Human Services and other providers, referrals easily address each individual situation with the most appropriate resources. Likewise, CHS is a member agency of the Greater Pittsburgh Community Food Bank. This relationship not only provides funding, food, and technical assistance, but also better connects families facing hunger with timely resources that are easily accessible to them.

Local Universities

CHS has a rich relationship with local universities. As an ongoing partner, the University of Pittsburgh provides undergraduate and graduate student interns through the Schools of Social Work, Nursing, and Occupational Therapy. CHS serves as a site for both the Browne Fellowship program as well as Bridging the Gaps, involving students from diverse backgrounds in community based social services. Broad and lasting products have resulted from these close collaborations. Both the Oakland Community Pantry and the Health Education Center, a set of resources provided by nursing students to engage pantry customers in making healthful decisions, were created in partnership with students and faculty from the University of

Pittsburgh. The University has also been a source of training on best practices in mental health for CHS program staff, enabling the agency's In-Home Services Program to better support people with complex physical and mental health conditions. The lead staff on the project proposed here as well as the consultant who led the research into selecting evidence-based decision support tools critical to the project both are alumnae of the School of Social Work who built their relationship with CHS through the agency's partnership with the University.

University faculty play a critical role in research and evaluation. Faculty from the University of Pittsburgh School of Public Health joined CHS staff to create and implement the aforementioned PhotoVoice project on the experience of a housing crisis, which has informed service delivery both within CHS and across the Allegheny County Continuum of Care. Recognizing CHS' capacity for research, the School of Social Work has held graduate-level community based participatory research classes at the CHS community center, co-taught by CHS staff.

These relationships extend beyond just the University of Pittsburgh. The agency just recently completed pro-bono branding projects with the Art Institute of Pittsburgh's Design Studio and the Duquesne University School of Business. Students and faculty provided valuable insight into how to talk about complex human services to the general public while being exposed to and experiencing firsthand the importance of the social service sector. Whether directly related to service delivery or supporting agency operations, CHS has successfully forged mutually beneficial relationships most appropriate for each challenge the organization faces.

Partnership and Collaboration with DHS

CHS has been and remains a long-term partner with DHS in the spectrum of housing and human support services, from empowering people with disabilities to live independently in the communities to preventing homelessness to providing supportive housing for adults with severe and persistent mental illness. These collaborations extend far beyond funding: informing policies and service delivery systems, building relationships among service providers, and providing trainings to DHS staff. CHS has a seat on the Homeless Advisory Board, and CEO Adrienne Walnoha participated in the DHS Block Grant Advisory Board. Working together, this relationship has produced tremendous benefits for both partners. CHS has improved assessment and evaluation processes in its programs while informing DHS decision-making with the latest view from on-the-ground direct service delivery.

CHS is well-positioned to design and implement decision support tools that are effective and appropriate to the Department's work because the agency has worked with multiple departments within DHS, including the Office of Community Services, the Office of Behavioral Health, the Area Agency on Aging, Office of Children, Youth, and Families, and staff within the Office of Data Analysis, Research and Evaluation. CHS staff members work closely with DHS database systems, including HMIS and eCaps, which lead to a familiarity with the existing systems and their use by frontline staff. CHS staff will focus on developing and implementing these proposed decision support tools within its existing programs to directly improve services to people in housing crises. CHS will work closely with current contacts within the Offices of Community Services and Data Analysis, Research and Evaluation to explore system-wide

implementation of these tools to improve the assessment and decision process of all organizations work to prevent housing crises in Allegheny County. While CHS possesses individual and organizational expertise on assessing people in housing crisis, these tools will be most effective if created with the input of DHS for system-wide replication.

Upon selection of this proposal, CHS will also engage with DHS information technology staff and its outside IT partners to ensure that digital versions of the tools implemented in this project smoothly integrate with the existing data warehouse. CHS' information technology infrastructure, expertise in data-informed decision-making, and history of working closely with DHS and other service providers to directly deliver the highest quality services possible uniquely positions the agency to effectively implement these tools and improve the delivery of services to people in housing crises.

Project Description

Project goals and objectives

Community Human Services (CHS) provides high quality services for individuals and families experiencing a housing crisis or homelessness. As a leader in human services, CHS looks to use its internal capacity, organizational history, and research to improve consumer experiences. CHS leadership has prioritized the development of a single point of entry and coordinated assessment process for individuals and families to access homeless assistance services. The new model will expedite eligibility determination and enrollment in CHS programs. Additionally, a coordinated assessment and decision-support tool, concurrently implemented, will increase the quality of homeless assistance services and help more people to find housing security and permanency.

The restructuring of the intake process will allow individuals and families in Allegheny County to receive CHS services that most closely meet their needs quickly and efficiently. CHS will simultaneously utilize current and newly developed IT infrastructure to more accurately track progress, outcomes, and the quality of services. The new CHS coordinated assessment and decision-support tools provide a model for all homeless services in Allegheny County to quickly and effectively connect people in housing crises with the support they need to avoid trauma and stabilize their situation.

CHS' existing infrastructure supports the development of a coordinated assessment process. However, the development of an agency-wide new process requires more than just a single decision-support tool. A coordinated assessment process requires the implementation of proven strategies used by organizations and systems across the United States. Focusing on coordinated assessment and decision-support tools allows CHS to improve the consumer experience by eliminating wait time for eligibility and more appropriately designate resources to individuals and families who most need them.

Prevention and diversion strategies do not prevent people from utilizing services, but instead focus on finding existing formal and informal supports that may prevent entering the homeless system. The National Alliance to End Homelessness states that 20 to 30 percent of individuals and families experiencing a housing crisis or homelessness can avoid involvement with the system through the prioritization of homeless prevention and diversion strategies (National Alliance to End Homelessness, 2013). CHS began using this approach in addition to the housing first approach in the 1990's prior to it becoming a national best practice.

While prevention strategies aim to help an individual or family avoid losing their housing, diversion strategies focus first on assessment, service planning, and then finding temporary housing outside of shelter (National Alliance to End Homelessness, 2012b). In other words, diversion focuses on individuals and families as they apply to enter into shelter (National Alliance to End Homelessness, 2011a), which often manifests as crisis services. Some strategies for both prevention and diversion may include, but are not limited to, searching for housing, providing a rental subsidy or other financial assistance, case management, and mediation (National Alliance to End Homelessness, 2012b). CHS already uses this model when working with individuals and families in a housing crisis, as about 66 percent of individuals and families served by homeless assistance programs receive eviction prevention, crisis intervention, and utility or rental assistance. The organizational culture, history, and current practices of CHS support the implementation of coordinated assessment and adjoining decision-support tools.

At its core, CHS believes that every person has value, and every person deserves a place to call home. The development, implementation, and evaluation of coordinated assessment and decision-support tools makes those values a reality by quickly connecting each person seeking services with the resources that best enable them to keep or gain a stable place to live. However, coordinated assessment only works when staff have standardized decision-support tools to assess, guide, and track services for consumers. At the same time, decision-support tools only work when implementation focuses on all options within the homeless assistance programs. The coordinated assessment process and decision-support tools rely on one another in development, implementation, and evaluation, as detailed below.

Goal 1: Develop, implement and evaluate a coordinated assessment model for CHS homeless assistance services.

Objective 1: Develop a coordinated assessment to meet the needs of CHS and its consumers

The National Alliance to End Homelessness recommends a centralized intake process with a single point of entry for communities that encompass a smaller geographic region and/or rely on an adequate mass transit system (National Alliance to End Homelessness, 2011b). With a centralized, transit-accessible location, CHS proposes to develop and implement a best-practice coordinated assessment process within a single physical location for consumers to enter into the homeless system. CHS already has a central location at 1945 Fifth Ave in Uptown that is within two blocks of 14 different bus lines, making it accessible to individuals and families from around the city and inner-ring suburbs. The highest numbers of CHS consumers originate from the East Side, North Side, South Side, Oakland and the Hill District. The majority of other CHS

consumers live in the neighborhoods of Wilkinsburg, Penn Hills, Carrick, and Beltzhoover. The new coordinated assessment process will build on this single convenient location with new decision support tools, database systems, and a revised physical office space to efficiently and effectively connect individuals and families in housing crises to the services that best meet their needs, reduce trauma, and result in having a permanent, stable place to live.

The easiest, and most cost-effective, way to reduce that trauma is to focus on preventing the housing crisis. In developing a coordinated assessment process, staff will continue to prioritize housing as the primary goal of homeless assistance programs. A coordinated assessment process must emphasize housing solutions and then refer to other interventions to address environmental factors such as employment or food insecurity (National Alliance to End Homelessness, 2013). The combination of this coordinated assessment process, extensive experience using a housing-first approach, homeless services backed up by diverse internal food, health, and educational resources, and strong community partnerships makes CHS well-positioned for implementation.

A high-quality coordinated assessment process has a tiered approach, first assessing access to existing housing options, then assessing eligibility for prevention and diversion. Initial assessments look for low-impact interventions that will resolve a housing crisis, including rental assistance or landlord mediation (National Alliance to End Homelessness, 2011b). Organizations and systems that first explore prevention and diversion options prevent individuals and families from the high stress experience of entering the homeless system via traditional shelters or other high-cost and high-impact interventions (National Alliance to End Homelessness, 2011b). CHS prioritizes prevention and diversion as seen through annual service numbers. Staff, focused on finding the easiest path to housing, can help to keep people in current housing or find low-impact alternatives to traditional homeless services. They then can provide referrals to other supportive resources within or outside of the agency to ensure stability. Internal programming such as the food pantry, health programs, early head start, and the partnerships listed above demonstrate CHS' capacity to provide individuals and families with supportive services and resources to stabilize their situation and reach their goals.

The second tier focuses on emergency shelter and rapid re-housing. Individuals and families may need to spend a few days in an emergency shelter until rapid re-housing or other housing options manifest themselves. Rapid re-housing workers work with the individual or family to find adequate, safe, and appropriate housing as soon as possible. CHS was one of only 23 agencies nationally to take part in the Rapid-Rehousing Demonstration Project, again showing the agency's commitment to the fastest and least traumatic interventions that are effective for its consumers.

The third tier exists for some consumers who require additional assessment and intensive housing interventions such as permanent supportive housing for adults with serious and persistent mental illnesses or individuals experiencing chronic homelessness. These last resource interventions cost the most and consumers who utilize them must require this level of care (National Alliance to End Homelessness, 2011b).

CHS will develop a coordinated assessment process using centralized intake to efficiently and appropriately determine eligibility and match consumers with the option that best fits their situation. This model matches both best practices across the United States and the strengths and organizational structure of CHS. Successful coordinated assessment models understand and prioritize support of an individual or family to successfully navigate a housing crisis, referring them to necessary supportive services as needed, but not allowing non-housing supportive services to dictate the length of involvement within homeless assistance programs. The coordinated assessment structure will emphasize providing housing solutions and ending a housing crisis for individuals and families by providing the least amount of assistance for the shortest amount to time. Individuals and families in a housing crisis often know what they need to stabilize their housing. Clients who have the choice and empowerment to choose their own goals often also have higher success rates (National Alliance to End Homelessness, 2009). To make this model even more effective, CHS emphasizes consumer choice and empowerment throughout the agency, not just in homeless assistance programs.

Hope's involvement with CHS provides an excellent example of consumer choice and empowerment. Hope came to CHS through Wood Street Commons. She had a physical disability as well as a diagnosis of post-traumatic stress disorder. She heard about the CHS Sleep In for the Homeless, an advocacy and awareness event, and became a volunteer. As she learned more about CHS, she began using the pantry and then volunteered to be a member of the PhotoVoice community-based participatory research project. She began seeing the psychiatrist at the Wood Street clinic and worked with case managers from Homeless Assistance to move into her own apartment and reunite with her children. Throughout all of these steps, Hope chose to connect with the resources that best fit her situation at the time. Even more, Hope had the opportunity to use her gifts to volunteer in addition to receiving services from CHS. Individuals and families know that CHS will respect their dignity and self-determination as they seek to move through crisis into stabilization.

Objective 2: Implementation of coordinated assessment model

Coordinated assessment allows individuals and families experiencing homelessness or in a housing crisis to find the quickest way into housing with the least amount of barriers. This consumer-focused approach reduces potential trauma. For many agencies, the centralized intake model for coordinated assessment requires a paradigm shift as it focuses on ensuring people have housing then providing supportive services. CHS' commitment to the housing-first model since the 1990's makes it the ideal organization to pilot the coordinated assessment process. The team already understands and embodies the underlying philosophy of housing-first, enabling the agency to implement this coordinated assessment process with just training and education on the tools themselves.

CHS has already begun the process of working with the co-occupants of the 1945 Fifth Avenue space to create a safe and welcoming reception area for all people seeking services. CHS prioritizes the consumer and their experience, so the physical space is accessible and welcoming to all people and provides the additional services of showers, laundry, and a kitchen.

A receptionist will welcome consumers and provide an information packet as well as some tangible items such as a snack, calendar, and activities for small children. The loss or potential loss of housing causes an extreme amount of stress, so creating a welcoming and comfortable physical space is a critical part of the coordinated assessment process to alleviate some of that stress.

In addition to providing a comfortable and welcoming physical space, the process and the staff members respect the dignity and privacy of each individual or family in crisis and seek to reduce potential trauma associated with the homeless system. The coordinated assessment will prioritize gathering the information necessary to make an assistance decision and will only seek information directly related to the housing crisis or homelessness. Other data collection will occur when individuals or families enroll in a homeless assistance program or supportive service. By only collecting the information needed to make an informed decision, this process focuses on the consumer experience by minimizing the collection of other intrusive questions. This helps to develop a rapport not only between the individual or family and the intake coordinator but also between CHS and the community.

In a centralized intake model, the same staff member(s) completes the intake process for all people entering homeless assistance programs. This helps to ensure consistency and quality of services (National Alliance to End Homelessness, 2011b). CHS has developed a team of skilled workers dedicated to intake and assessment with over 50 years of combined human service experience. The director has is a Master's in Social Work with a Pennsylvania license. Data entry and IT personnel will also support the coordinated assessment process to ensure that CHS can assess and match the highest number of consumers with needed services.

Weekly coordinated assessment team meetings will review cases and refer individuals or families to internal or external services as recommended by the team. Some situations may require action prior to the next team meeting. Intake coordinators will consult the rest of the team and the Director of Customer Service and Intake to ensure that individuals and families in crisis do not lose housing unnecessarily. The intake coordinator will discuss potential options with the individual or family based on eligibility. The process emphasizes transparency by clearly sharing with consumers the duration, requirements, availability, and wait time for each program option. This transparency will help the consumer to make informed decisions if they want to participate in services and what option best meets their needs.

The decision-support tools, as described in Goal 2, will guide coordinated assessment workers in providing a standardized assessment of needs and eligibility. The decision-support tools will capture both quantifiable data as well as nuances of individual cases. The combination of standardized assessment and professional opinion of workers allows the coordinated assessment team to have a well-rounded and consistent understanding of each individual or family. The use of the decision-support tools will continually increase the use and understanding of data in the daily activities of intake coordinators.

Objective 3: Continuous quality improvement activities

CHS has committed to agency-wide continuous quality improvement activities such as the Quality Committee. The intake and coordinated assessment processes will also participate in quality improvement activities. While the decision-support tools have separate quality improvement mechanisms, quality improvement activities for intake and coordinated assessment will focus on the process. CHS will gather data and make process improvements through 1) progress on team and individual staff metrics; 2) weekly team meetings; 3) quarterly formal process evaluations; and 4) annual qualitative consumer satisfaction surveys.

The Director of Customer Service and Intake, intake coordinators, consumer liaison, along with data entry and IT support, will see the long-term outcomes of people who enter CHS homeless assistance programs as tracked through an agency-wide data system. Intake coordinators will have both team and individual goals to meet based on the coordinated assessment process and metrics determined by the team. For example, the team may have a weekly goal of collecting 90 percent usable data or to keep wait time at the centralized intake for individuals and families to less than 15 minutes. Individual and team goals help to focus and energize the team, while simultaneously working to improve the quality of services. Weekly team meetings will provide a space for discussion about the progress on metrics and potential process improvements in addition to quarterly formalized process evaluations. This ongoing dialogue allows for a two-way conversation about what works well in the coordinated assessment process and what changes need made.

Quarterly qualitative surveys will provide another mechanism to measure success. Several tools exist to gather feedback from administrators, supervisors, and front-line staff (National Alliance to End Homelessness, 2012a). The CHS Coordinated Assessment Administrator Survey will help to gauge the long-term success of coordinated assessment and give guidance at the agency level to improve the process and consumer experience.

CHS will evaluate the consumer experience and satisfaction on an annual basis. One consumer survey by the NAEH (2012a) examines if coordinated assessment helped to shorten the length of time between homelessness and permanent housing. This tool, along with another qualitative assessment consumer survey produced by the NAEH (2010), provide guidelines for the CHS Coordinated Assessment Consumer Survey and will help the coordinated assessment team to continually improve services from consumers' perspectives. The coordinated assessment team will focus on individual and team goals, process evaluation, and consumer feedback to ensure consumer receive a continuously improving high quality service.

Goal 2: Develop, train, and implement decision-support tools

Objective 1: Develop a decision-support tool to meet the needs of CHS and its consumers.

CHS has combined several tools in developing a decision-support tool for the coordinated assessment process and team (CHS Coordinated Assessment) and will implement an

internationally recognized decision-support tool in its homeless assistance programs (SPDAT). Both tools will help to centralize and standardize CHS homeless services while simultaneously increase data integration.

CHS Coordinated Assessment:

The CHS Coordinated Assessment uses self-report by individuals and families experiencing a housing crisis or homelessness to answer a series of questions to determine program eligibility. Based on national models and standards, these questions target needs related to housing. The simple scoring system gives clear guidance for types of assistance. Scoring results indicate one of four categories for homeless assistance: prevention, diversion, rapid re-housing, and permanent supportive housing.

Prior to meeting with the intake coordinator, individuals and families will complete the CHS Triage Form, to determine need for homeless assistance services. This initial triage component saves individuals and families seeking other supports from waiting for an unnecessary assessment process. The consumer liaison will meet with individuals and families who do not meet the threshold for homeless assistance services and assess and provide information and referrals for needed internal and external services.

Intake coordinators will meet with individuals and families who meet the threshold for homeless assistance services to complete the decision-support tool. The CHS Coordinated Assessment asks general questions about the individual or family's housing crisis. Based on the answers to these questions, the intake coordinator will follow one of two paths within the tool to determine eligibility. The CHS Coordinated Assessment separates consumers into groups, prevention/diversion and rapid re-housing/permanent supportive housing based on the housing options and informal resources available to each consumer. Questions then focus on specific indicators for what service may best match the needs of the individual or family.

The tool has a clear visual path based on the information given by the consumer. While the CHS Coordinated Assessment uses self-report by consumer, team members may take notes of other needs as they present themselves. For example, if physical or behavioral signs suggest that family members have not eaten well for a few days, an immediate referral may be made to the CHS food pantry. The internal capacity and diverse programing at CHS allows for external factors, such as food, to receive immediate attention. The integration of these services into the coordinated assessment process enables CHS to respond holistically to consumer situations, better supporting individuals and families in reaching their goals.

Intake coordinators complete the CHS Coordinated Assessment for individuals or families that follow predictive indicators for prevention or diversion. An existing tool called the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT) is built into the CHS Coordinated Assessment for individuals or families with more complicated housing needs who require rapid re-housing or permanent supportive housing. Adding this additional tool to the CHS Coordinated Assessment allows intake coordinators to make a more detailed and quantified assessment for consumers with complex needs. Both tools use self-report to come to

a decision; however, coordinated assessment workers have the opportunity to override the results of the tool by providing documentation.

The consumer and the intake coordinator will then complete the CHS Intake Form to confirm eligibility for CHS homeless assistance programs and automatically create a single electronic record for their engagement with CHS, minimizing duplicative data entry. The intake coordinator will provide options for homeless assistance programs based on eligibility and availability to the individual or family. If the individual or family is not eligible, the intake coordinator will provide resources for other services within the Continuum of Care that they may be eligible. The Quality Committee recently developed a universal intake form for all CHS services. The form encompasses all required intake information for CHS programs. Now in early implementation, the CHS Intake Form will help intake coordinators to determine eligibility with individuals and families during their first meeting.

At the weekly team meeting, the worker will then bring the case to the team, who will confirm the best service and eligibility determination to offer the individual or family. These tools provide workers with a standardized researched-based tool to use as they make decisions regarding homeless assistance. Please see the sample CHS Coordinated Assessment in the appendix for visual support to help with decision-making.

Service Prioritization Decision Assistance Tool (SPDAT):

CHS will integrate the Service Prioritization Decision Assistance Tool (SPDAT) into homeless assistance program case management. The SPDAT combines self-report by consumers, observations by social service professionals, and supporting documentation to develop a standardized assessment. The SPDAT offers some flexibility in its administration. People experiencing homelessness should receive the SPDAT within the first two meetings after program enrollment to develop a baseline for data collection purposes. Administration takes about forty-five minutes and can occur over one or two meetings (OrgCode Consulting, 2013).

The SPDAT comprises 15 domains to capture a full picture of a consumer's immediate needs and progress. Based on a variety of questions and prompts, case managers can make assessments based on a scoring system as well as their observations (OrgCode Consulting, 2013). The incorporation of case manager observation allows SPDAT administrators to operationalize and quantify the nuances of individual cases and families to provide services based on holistic information. SPDAT scoring is based on a four-point scale. A score of "0" indicates high functioning or an area that does not need supportive services. The score of "4" indicates a component in need of immediate intervention. The administrator of the SPDAT has the ability to assess the situation and note discrepancies between the self-report of a consumer and observations and/or documentation (OrgCode Consulting, 2013). The tool increases the transparency and rapport between the worker and consumer, as correct implementation looks very similar to a conversation based on the 15 domains. The scores clearly indicate to both the individual or family and the worker the areas of progress and opportunities for additional support.

The SPDAT allows for additional data collection and tracking over the course of a consumer's interaction with homeless assistance programs. Recommended intervals include: enrollment, at move (if applicable), 30 days, 90 days, and 180 days and/or at exit from program (OrgCode Consulting, 2013). This will provide a standardized tool across all CHS homeless assistance programs to more accurately compare outcomes within and between programs.

CHS will implement a decision-support tool as part of its restructured intake and coordinated assessment process for its homeless assistance programs. Based on national standards and best practices, CHS' restructured intake process and decision-support tools combine nationally recognized tools and assessment of individuals and families for other CHS supportive services in a way that is directly integrated with agency electronic databases to quickly and effectively connect people with the supports that best fit their situations. The CHS Coordinated Assessment will provide intake coordinators and the SPDAT will assist homeless assistance program case workers with a standardized guide for assessment of individuals and families experiencing a housing crisis or homelessness.

The Service Prioritization Decision Assistance Tool (SPDAT) and the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT), along with their corresponding family versions, provide researched-based tools for assessment, decision-making, data collection, and analysis for homeless assistance programs. The SPDAT and VI-SPDAT are used and recognized internationally (De Jong, 2014) for excellence in assessing vulnerability, service needs, prioritizing individuals and families for permanent supportive housing and evaluating client progress throughout programs and case management (National Alliance to End Homelessness, 2013). The SPDAT and VI-SPDAT categories have integrated into the CHS Coordinated Assessment tiers of prevention/diversion, rapid re-housing/shelter, and permanent supportive housing.

Objective 2: Implement decision-support tools

Implementation of the decision-support tools requires training and coaching with an emphasis on data integration. Prior to implementation, administrators of the CHS Coordinated Assessment and the SPDAT must receive training. OrgCode provides training for the full SPDAT via webinar or in-person and free training for the VI-SPDAT is available online. Research by OrgCode (2013), in conjunction with the National Alliance to End Homelessness indicates that use of both instruments have resulted in measuring outcomes, decrease in recidivism, and allows for staff to use their time more effectively.

The Director of Customer Service and Intake will ensure that all coordinated assessment workers receive both the required training on the CHS Coordinated Assessment, VI-SPDAT and integration into the agency database system. This training will include understanding the research and best practices behind the questions and format plus several practice sessions. Training will also include technical and administration techniques and guides. Ongoing coaching will ensure standardized administration and scoring. The Director of Customer Service and Intake will also ensure training of the SPDAT with all homeless assistance program staff.

Increased data collection and analysis is an important component of implementing the decision-support tools. The coordinated assessment team will receive training on how to understand the data collection and its importance. Training for the decision-support tool will include easy-to-understand mechanisms to collecting, tracking, and analyzing data. This same process will occur in case management in CHS homeless assistance programs with the implementation of the SPDAT.

Objective 3: Evaluate decision-support tool

The two decision-support tools, the CHS Coordinated Assessment and the SPDAT will take several months for the coordinated assessment team and homeless assistance program caseworkers to receive training and implement. During training and every quarter thereafter, the Director of Customer Service and Intake will coordinate evaluations of the tools and implementation.

Along with process evaluations, quarterly evaluations will include quantitative and qualitative components. A review of data collection rates and quality of data will indicate to CHS any technical barriers that may exist to successful data collection. The intake team will provide qualitative feedback describing their experiences with the CHS Coordinated Assessment. CHS will also survey current and former CHS consumers at least once a year to gain a consumer perspective on the two tools and will implement changes based on this feedback. CHS will make changes and provide additional technical assistance, reformatting, and/or training as needed to improve the quality of the tools and their implementation.

The training on the SPDAT tool for all staff in CHS homeless assistance programs will take a significant period of time. Case management tracking and consumer progress will increase with agency-wide implementation. The model of transparency in the SPDAT allows caseworkers and consumers to have honest and operationalized conversations about goals and progress. CHS will evaluate SPDAT usage rates and programmatic outcomes, controlling for usage, every six months. As programs begin to use the SPDAT, CHS can track its success while also getting feedback from caseworkers.

This restructured intake and coordinated assessment process at CHS, which integrates research-based best practices and the organizational expertise of CHS, seeks to provide a more efficient and welcoming consumer experience. It also allows for broader system integration and outcomes for homeless services within the agency. Organizations throughout Allegheny County can also use this model to further intake systems and increase data collection and outcomes. Many organizations do not have an internal data collection system and must rely on funder-driven systems, which may not meet the needs of the entire organization. CHS strives to provide a model for organizations throughout Allegheny County to use internal decision-support tools and data collection systems to increase outcomes and system integration. The model proposed by CHS allows for adaptation and customization in partnership with DHS to meet the needs of organizations and still maintains the integrity of the tools. The national and research-based tools adapted by CHS have been shown to be appropriate and effective across many types of homeless service providers working with people from diverse backgrounds and

settings. By funding the development and implementation of these tools locally, DHS has the opportunity to not only improve the assessment and delivery of services at CHS but also to the entire range of local organizations serving people in housing crises.

Describe how the program will be integrated with other information technology and tools

The CHS Coordinated Assessment will integrate into CHS' new database alongside the agency-wide Intake Form. This will allow intake coordinators to collect and track individuals and families as they navigate through CHS homeless assistance programs. Electronic data collection will allow automatic scoring and ease of use of the CHS Coordinated Assessment. As the validity and effectiveness of the Coordinated Assessment is solidified by thorough evaluation in partnership between CHS and DHS, this digital tool can potentially be integrated within the County's data warehouse. The integration presents a potential joint effort between CHS staff, DHS staff, and DHS information technology vendors.

The SPDAT is compatible with most Homeless Management Information Systems. OrgCode Consulting, Inc. provides the tool and additional technical assistance to HMIS administrators for free with a signed contract agreement protecting the intellectual property of the tool (De Jong, 2014). CHS homeless assistance providers who already use HMIS as their electronic data collection system will continue to report necessary data to HUD as well as integrate important case information and tracking. As the use of the SPDAT increases in Allegheny County, other HMIS users from other providers will continue case management tracking through HMIS of individuals and families in the homeless system.

While these tools utilize information technology resources, the coordinated assessment and decision-support process proposed here has the potential to integrate broadly into the work of the Allegheny County Continuum of Care to improve the operations of the system as a whole. The research-based model of using decision-support tools in conjunction with coordinated assessment allows CHS to continue focusing on customer services as well as high quality data collection and assessment.

As a leader in human services, CHS seeks to work with other organizations to develop and implement their own model of coordinated assessment. By using CHS' experience with what works within the coordinated assessment model and areas to further develop, other organizations will have the benefit of working with a leader in human services with the systemic backing of DHS. The replication of this model will increase system integration, and the delivery of more timely and effective housing services, across Allegheny County.

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National Alliance to End Homelessness (2013). "Coordinated Assessment: Understanding Assessment Tools." *National Alliance to End Homelessness*. Retrieved from http://www.endhomelessness.org/library/entry/webinar-coordinated-assessment-understanding-assessment-tools. Webinar. 11/6/13.
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Design and Development Timeline

	Months 1-3	Months 4-6	Months 7-9	Months 8-12
Year 1				
CHS Coordinated Assessment Training	x	x		
VI-SPDAT/F-VI-SPDAT Training	x	x		
SPDAT/F-SPDAT Training			x	x
Coordinated Assessment Process Evaluation	x	x	x	x

CHS Coordinated Assessment Evaluation	x	x	x	x
SPDAT/F-SPDAT Evaluation	x		x	
Consumer Feedback Survey				x
Year 2				
Coordinated Assessment Process Evaluation	x	x	x	x
CHS Coordinated Assessment Evaluation	x	x	x	x
SPDAT/F-SPDAT Evaluation	x		x	
Report to DHS on Coordinated Assessment Process		x		x
Consumer Feedback Surveys				x
Year 3				
Coordinated Assessment Process Evaluation	x	x	x	x
CHS Coordinated Assessment Evaluation	x	x	x	x
SPDAT/F-SPDAT Evaluation	x		x	
Report to DHS on Coordinated Assessment Process		x		x
Consumer Feedback Surveys				x
Develop Training on Coordinated	x	x	x	x

Assessment Process for Replication				
Year 4				
Coordinated Assessment Process Evaluation	x	x	x	x
CHS Coordinated Assessment Evaluation	x	x	x	x
SPDAT/F-SPDAT Evaluation	x		x	
Report to DHS on Coordinated Assessment Process		x		x
Consumer Feedback Surveys				x
Implement Trainings on Coordinated Assessment Process	x	x	x	x
Technical Assistance for Replication		x	x	x
Year 5				
Coordinated Assessment Process Evaluation	x	x	x	x
CHS Coordinated Assessment Evaluation	x	x	x	x
SPDAT/F-SPDAT Evaluation	x		x	
Report to DHS on Coordinated Assessment Process		x		x
Consumer				x

Feedback Surveys				
Implement Trainings on Coordinated Assessment Process	x	x	x	x
Technical Assistance for Replication		x	x	x

Tools Already Developed

Examples of the following tools/systems are available in the attached appendix:

A. CHS Triage Form
B. CHS Coordinated Assessment, including VI-SPDAT
C. SPDAT (property of OrgCode Consulting, Inc.)
D. CHS Coordinated Assessment Consumer Survey
E. CHS Coordinated Assessment Staff Process Evaluation
F. CHS Intake Form

Staffing Plan Overview

Resumes and/or job descriptions are available in the attached appendix:

1. Director of Customer Service and Intake: Natalie Ryan
    a. Role:
        i. Recruit, train, and supervise intake coordinators, consumer liaisons, and receptionists
        ii. Collect assessments and assist intake coordinators in eligibility determination
        iii. Coordinate process and decision-support tool evaluations
    b. Qualifications:
        i. BA/BS degree or any combination of life, work and educational experiences
        ii. 3 years case management/intake experience
        iii. Crisis management skills
        iv. Supervisory skills
        v. Strong organizational, communication and management skills
        vi. Ability to manage multiple components of a project in various stages of completion

vii. Sensitivity toward individuals and families in need of program services
viii. Commitment to the project and the agency's mission
ix. Willingness to work collaboratively with staff and other organizations to achieve goals
x. Advanced computer literacy
xi. A working knowledge of county social service system
xii. The ability to travel independently

2. Intake Coordinator
    a. Role:
        i. Process incoming applications
        ii. Complete initial assessment to determine eligibility
        iii. Assign program/case manager
        iv. Input consumer data
    b. Qualifications:
        i. BA/BS degree or any combination of life, work and educational experiences
        ii. 1 year case management experience
        iii. Strong organizational, communication and management skills
        iv. Ability to manage multiple components of a project in various stages of completion
        v. Sensitivity toward individuals and families in need of program services
        vi. Commitment to the project and the agency's mission
        vii. Willingness to work collaboratively with staff and other organizations to achieve goals
        viii. Basic computer literacy
        ix. A working knowledge of county social service system
        x. The ability to travel independently

3. Consumer Liaison
    a. Role:
        i. Assist individuals and families to find applicable resources outside of CHS
        ii. Assist individuals and families understand and navigate intake system
        iii. Support work of Intake Coordinators, Receptionist, and Director of Intake and Customer Service
    b. Qualifications:
        i. Excellent interpersonal skills
        ii. Strong organizational, communication, and management skills
        iii. Sensitivity toward individuals and families in need of program services
        iv. Commitment to the project and the agency's mission
        v. Willingness to work collaboratively with staff and other organizations to achieve goals
        vi. Basic computer literacy
        vii. A working knowledge of county social service system

viii. The ability to travel independently

4. Receptionist
    a. Role:
        i. Welcome all walk-in consumers
        ii. Maintain appointment log
        iii. Distribute CHS Triage Form, review with consumers, and assist with completion
    b. Qualifications:
        i. Excellent communication and interpersonal skills.
        ii. Strong organizational, phone and computer skills.
        iii. A working knowledge of the social service system through life or job related experience.
        iv. A willingness to work collaboratively in a team setting, yet have the ability to work independently.
        v. Strong ability to navigate the World Wide Web to familiarize and access various resources.

5. Chief Technology Officer: Paul Mosey
    a. Role:
        i. Develop digital versions of decision support tools integrated into CHS' single program database
        ii. Provide ongoing technical assistance to intake team to ensure effective training and implementation
        iii. Collaborate with DHS to integrate these tools into the DHS Data Warehouse for replication among other providers
    b. Qualifications:
        i. 10 years of information technology experience
        ii. Ability to develop, maintain, and troubleshoot computer networks and database systems
        iii. Experience developing responsive, mobile-friendly web-based tools
        iv. Advanced knowledge of Drupal, HTML, CSS, PHP, and AJAX
        v. A working knowledge of county social service system
        vi. The ability to travel independently

6. Administrative Consultant: LauraEllen Ashcraft
    a. Role:
        i. Execute the restructuring of CHS homeless assistance intake
        ii. Develop assessment and evaluation tools
        iii. Train CHS staff on assessment tools and
        iv. Assist in completion of assessment tool evaluation
        v. Support full implementation of intake process and adjoining assessment tools
    b. Qualifications

i. Master's degree in human service related field
ii. Intimate understanding of assessment and program evaluation
iii. Intimate understanding of county social service system
iv. High-level research and analysis skills
v. Working knowledge of best practices in homeless services

References

1. Michael Yonas
   Allegheny County Department of Human Services
   [redacted]
2. McCrae Martino
   The Forbes Funds
   (412) 394-2639
   martino@forbesfunds.org
3. Tracy Soska
   University of Pittsburgh School of Social Work
   (412) 624-3711
   tsssw@pitt.edu

Decision Support Tools in Human Services Proposal Budget
Community Human Services

Budget Item	Explanation of Costs	Amount Requested from DHS	Costs Shared by Other Program Contracts	Total Cost
Personnel				
Director of Customer Service and Intake	Partial salary and fringe benefits to offset costs associated with developing and implementing new system; remainder funded across agency homeless assistance contracts	[redacted]	[redacted]	$[redacted]
Chief Technology Officer	Partial salary and fringe benefits to offset costs to integrate decision support tools into agency data systems	[redacted]	[redacted]	$[redacted]
Consultant	Consultant fees in implementing and evaluating decision support tools	[redacted]	[redacted]	$[redacted]
Intake Coordinator	Salary and benefits funded across agency homeless assistance contracts	[redacted]	[redacted]	$[redacted]
Consumer Liaison	Salary and benefits funded across agency homeless assistance contracts	[redacted]	[redacted]	$[redacted]
Operating Costs				
Technology	6 tablet computers for implementing assessment tools, estimated at $500 each	[redacted]	[redacted]	[redacted]
Administrative Costs				
Administrative overhead	Fiscal oversight, audit costs, human resources, and other administrative support, estimated at 11% of overall project budget	[redacted]	[redacted]	$[redacted]
Total		[redacted]	[redacted]	$[redacted]

Decision Support Tools in Human Services Proposal Budget Description
Community Human Services

CHS requests $50,000 in financial support to finalize, implement, and evaluate these decision support tools. While CHS already has significant program, facilities, and technology resources, funding for staff time is critical to the implementation of this intake and coordinated assessment process. Implementation will be led by the Director of Intake and Customer Service, who holds a Master of Social Work and a Pennsylvania license. Developing and implementing this new process will require focused work beyond the scope of current program staff funded through contracts. CHS requests $20,000 to offset the salary and fringe benefits associated with this project that cannot be assumed through traditional program contracts. Staffing costs of all other positions (intake coordinators, consumer liaisons, and receptionists) are shared across all agency homeless assistance program contracts.

This implementation will be supported by the ongoing work of a consultant, also holding a Master of Social Work, who has engaged with CHS to develop and implement both the agency-wide Intake Form as well as the tools used in the CHS Coordinated Assessment. Her expertise in intake and assessment, as well as institutional knowledge working with this project since its beginning, is critical to the successful implementation and evaluation of the process. CHS requests $10,000 to support consulting fees. To date, she has donated significant time pro-bono in the creation of the Intake Form, maximizing the value and impact of her work.

Technical implementation of the assessment tools includes integration in the agency's existing CiviCRM-based databases, which requires the expertise of the Chief Technology Officer. This position generates partial funding through the sale of IT services to other nonprofit organizations. Based on past work with this database system, CHS expects development to require at least 300 hours over the first 12 months of the project, limiting the agency's ability to generate revenue for this position through the sale of other services. CHS requests $12,000 in salary and fringe benefits to fund the 300 hours of his time.

CHS already maintains significant technology resources, including in-house servers to run the databases, remote backups, and staff computers. To streamline the implementation of the assessment and intake process, all of the database tools are designed to be mobile-friendly. Mobile tools within the office ensure a flexible and welcoming physical environment without the appearance of a clinical office. CHS requests $3,000 in funding to purchase 6 additional Windows-based tablet computers for implementing these tools within the intake office.

CHS programs are only effective because they have appropriate administrative support. The agency has a full-featured administrative team, including a three-member fiscal team for contract implementation and financial management, human resources, facilities management, and planning. The support of this team, as well as audit and insurance costs necessary for agency operations, is essential for the development and implementation of new agency tools

and resources. Based on costs for similar projects in the agency, these proportional costs amount to 11% of the program budget, and CHS requests $[redacted] to ensure these resources are available to support the intake and assessment team.

Please see the attached budget spreadsheet for detail.

Decision Support Tools in Human Services Proposal Appendices
Community Human Services

Examples of the following tools/systems:

Job Descriptions:

Resumes:

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Vulnerability Index & Service Prioritization Assistance Tool (VI-SPDAT)

Property of OrgCode, Inc.

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Concluding Questions (Intake Coordinator Only)

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Additional Notes:

Documentation Regarding Override:

Service Prioritization Decision Assistance Tool (SPDAT v3)

Disclaimer

The management and staff of OrgCode Consulting, Inc. (OrgCode) do not control the way in which the Service Prioritization Decision Assistance Tool (SPDAT) will be used, applied or integrated into related client processes by communities, agency management or frontline workers. OrgCode assumes no legal responsibility or liability for the misuse of the SPDAT, decisions that are made or services that are received in conjunction with the assessment tool.

Contents

Foreword

OrgCode Consulting Inc. is pleased to announce the release of Version 3 of the Service Prioritization Decision Assistance Tool (SPDAT). Since its release in 2010, the SPDAT has been used with over 10,000 unique individuals in over 100 communities across North America and in select locations around the world.

Originally designed as a tool to help prioritize housing services for homeless individuals based upon their acuity, the SPDAT has been successfully adapted to other fields of practice, including: discharge planning from hospitals, work with youth, survivors of domestic violence, health research, planning supports for consumer survivors of psychiatric care systems, and in work supporting people with fetal alcohol spectrum disorders. We are encouraged that so many service providers and communities are expanding the use of this tool, and OrgCode will continue to support the innovative use of the SPDAT to meet local needs.

In preparing SPDAT v3, we have adopted a comprehensive and collaborative approach to changing and improving the SPDAT. Communities that have used the tool for three months or more have provided us with their feedback. OrgCode staff has observed the tool in operation to better understand its implementation in the field. An independent committee composed of service practitioners and academics reviews enhancements to the SPDAT. Furthermore, we continue to test the validity of SPDAT results through the use of control groups. Overall, we consistently see that groups assessed with the SPDAT have better long-term housing and life stability outcomes than those assessed with other tools, or no tools at all.

OrgCode intends to continue working with communities and persons with lived experience to make future versions of the SPDAT even better. We hope all those communities and agencies that choose to use this tool will remain committed to collaborating with us to make those improvements over time.

SPDAT Design

The SPDAT is designed to:

- Help prioritize which clients should receive what type of housing assistance intervention, and assist in determining the intensity of case management services
- Prioritize the sequence of clients receiving those services
- Help prioritize the time and resources of Frontline Workers
- Allow Team Leaders and program supervisors to better match client needs to the strengths of specific Frontline Workers on their team
  Assist Team Leaders and program supervisors to support Frontline Workers and establish service priorities across their team
- Provide assistance with case planning and encourage reflection on the prioritization of different elements within a case plan
- Track the depth of need and service responses to clients over time

The SPDAT is NOT designed to:

- Provide a diagnosis
- Assess current risk or be a predictive index for future risk
- Take the place of other valid and reliable instruments used in clinical research and care

The SPDAT is only used with those clients who meet program eligibility criteria. For example, if there is an eligibility criterion that requires prospective clients to be homeless at time of intake to be eligible for Housing First, then the pre-condition must be met before pursuing the application of the SPDAT. For that reason, SPDAT v3 includes an initial screening tool to assess eligibility.

The SPDAT has been influenced by the experience of practitioners in its use, persons with lived experience that have had the SPDAT implemented with them, as well as a number of other excellent tools such as (but not limited to) the Outcome Star, Health of the Nation Outcome Scale, Denver Acuity Scale and the Camberwell Assessment of Needs.

The SPDAT is not intended to replace clinical expertise or clinical assessment tools. The tool complements existing clinical approaches by incorporating a wide array of components that provide both a global and detailed picture of a client's acuity. Certain components of the SPDAT relate to clinical concerns, and it is expected that intake professionals and clinicians will work together to ensure the accurate assessment of these issues. In fact, many organizations and communities have found the SPDAT to be a useful method for bridging the gap between housing, social services and clinical services. This matter is discussed in further detail at the end of this guide.

Family SPDAT

The Family SPDAT (F-SPDAT) was released in Spring 2012 and is designed specifically for working with families. If your organization would like a copy of that tool you can send your request to F-SPDAT@orgcode.com.

SPDAT Client Disclosure

Clients should be informed that you are using the SPDAT. It is best to explain SPDAT as a tool to help guide them to the right services, as well as assist with the case planning process and track changes over time for those clients that are referred to a case management team as a result of their SPDAT score. At intake or first assessment, it is also prudent to explain to the prospective client that the SPDAT helps to determine the priority with which they will get services and housing. It is important to let the client know that the final determination of a score for any component is a combination of conversation, documentation reviewed, observation and information from other sources. In other words, the outcome is not influenced solely by what they say.

Similar to transparency in case planning, the client should be offered a copy of the Summary Sheet of the SPDAT after it is completed. Whether they may accept or decline, a copy of each SPDAT should be kept in the client's file.

An evaluated best practice from versions one and two of the SPDAT was the use of the SPDAT in the "warm transfer" between intake and the case manager for clients with higher acuity. In the warm transfer, the intake worker, client and case manager (meeting the client for the first time) met together and reviewed each of the 15 components of the SPDAT in detail. Through this process, OrgCode learned:

- clients appreciated understanding the intake worker's assessment and transparency of their reasoning;
- clients appreciated the opportunity to provide commentary on the intake worker's assessment (even though the commentary did not have any further impact on the initial score);
- the receiving case managers appreciated the opportunity to learn more about the clients and ask questions of clarification from the intake worker with the client present;
- the receiving case managers were able to engage in the goal setting process of case planning quicker;
- there was greater continuity between intake and case management. As a result, fewer clients went "missing" between their initial intake and the beginning of the case management services;
- trust between the intake workers and case managers within the community was said to have improved; and,
- clients served through this approach achieved greater housing stability than those

Timing of SPDAT Implementation

It is recommended that the SPDAT begin at intake after the client has been screened for program eligibility. This can be accomplished at a central intake point for the entire community, at various intake points across community agencies and shelters, or upon specific program intake. Although any single organization will benefit from using the SPDAT, the value of the tool and the results it provides are improved as more organizations align in its use across any given service community.

The SPDAT assessment – especially the first assessment done with the client – does not need to be completed in just one client visit. Testing of the tool has demonstrated that there are no discernible differences in assessments conducted over several visits versus those completed in one visit. In the event that a client wishes to take additional time to consider their participation in a program, or in the event that the person conducting an assessment with the individual thinks that it would be advantageous to take a break, they are encouraged to do so. Should the accuracy of the information seem suspect to the person

conducting the interview based upon the client's self-report, keep in mind that the client's consent information can be corroborated from other sources. This type of cross-referencing may be critical for ensuring the best possible assessment that reflects the highest degree of accuracy.

The early application of the tool is a baseline for subsequent SPDAT measurement. The suggested intervals following the baseline SPDAT assessment are as follows:

1. Intake/Early in engagement, i.e., early stages of involvement of Housing Worker and client showing interest in being housed
   In the "warm transfer" between intake and case managers for those clients that are being recommended for supports based upon their SPDAT acuity
3. At or very shortly after (within 2 days of) move in for those clients that are receiving supports

For those clients that are receiving supports, the SPDAT should also be used:

- On or about 30 days
- On or about 90 days
- On or about 180 days
- On or about 270 days
- On or about 365 days

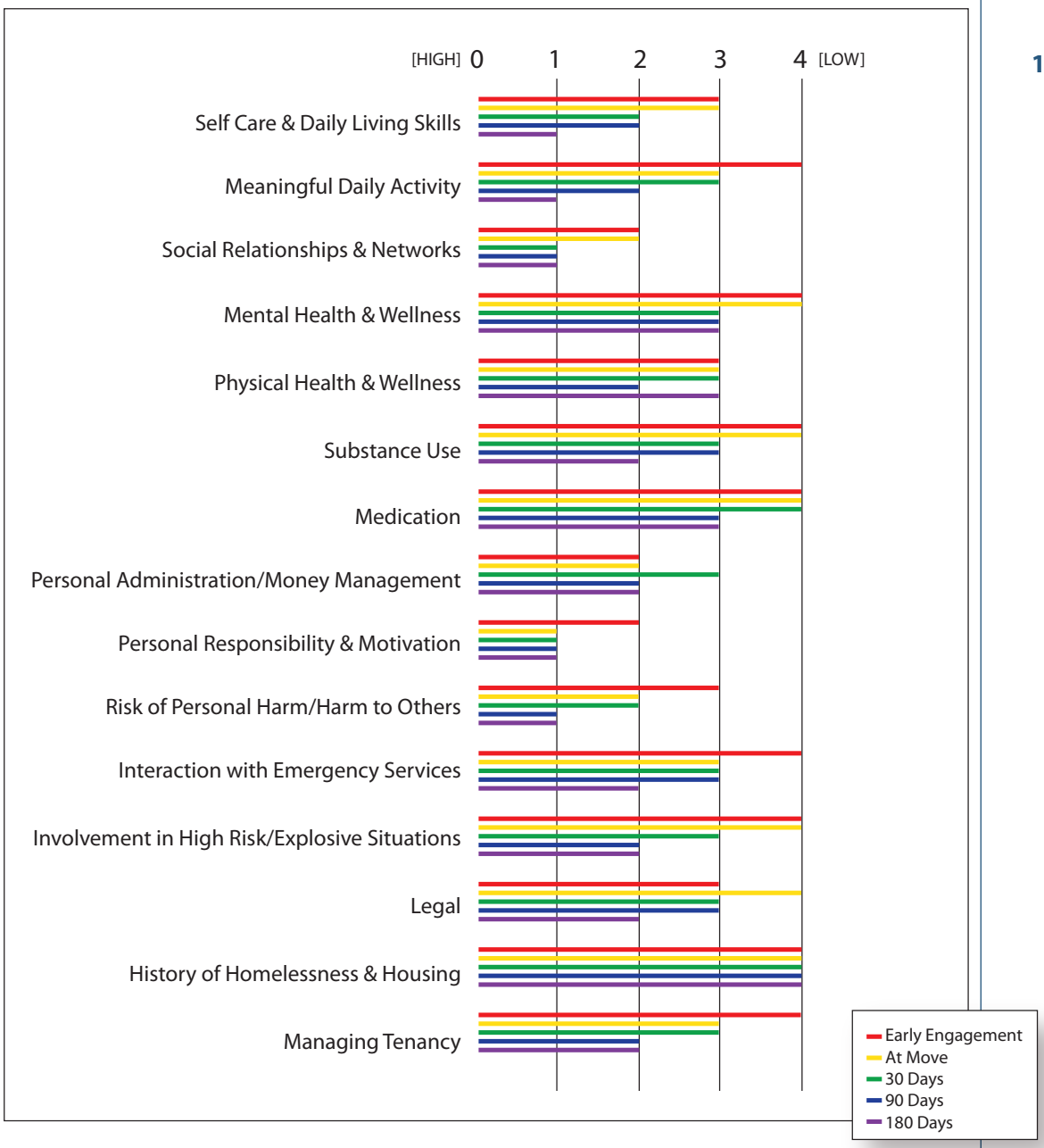
In addition, the SPDAT should be completed any time a client is re-housed or experiences a significant shift in their case plan, either positive or negative. As discussed later, it is not recommended that the SPDAT be completed when a client is in crisis as the episode may misrepresent the overall acuity score. If a client is in crisis, the SPDAT should be completed after the episode has subsided. This may occur in between regularly scheduled applications of the SPDAT.

Graphing Changes

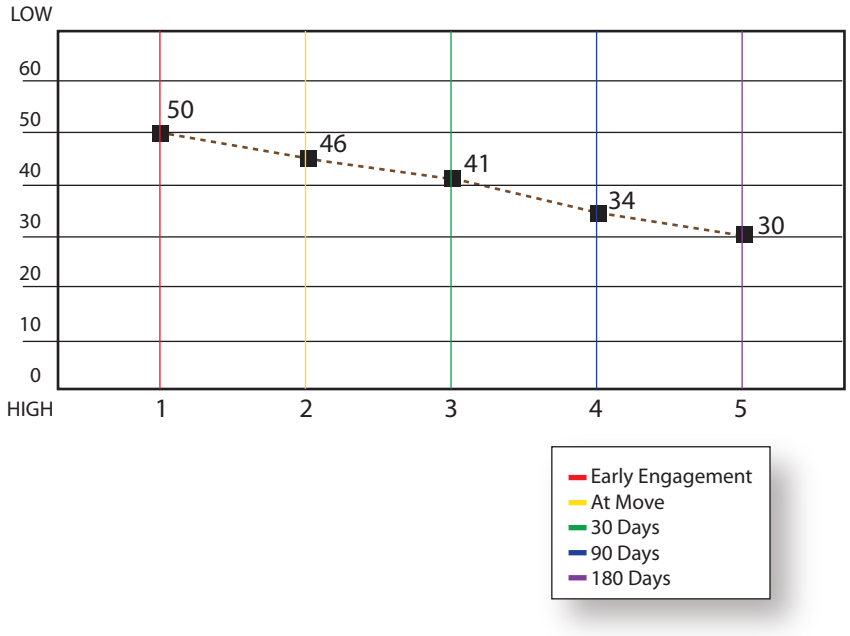
Visuals are an important adult learning strategy. Therefore, it is best practice to visually graph the client's transitions relative to the time intervals noted above. The two examples below illustrate graphing by component or by overall score. The graphs illustrate how the client was assessed during their 5th of 7 applications of the SPDAT—180 days:

Client Assessment

15 SPDAT Components



Client Assessment—Total Component Score



Approaches to Completing the SPDAT

The SPDAT can be completed through observation, conversation, other documentation shared in the intake or case planning process and a client's self-report. Information can also come from the client's case plan, information gleaned from home visits and community accompaniment, or existing knowledge from the client's engagement with your organization. While a conversational approach can be helpful when using the SPDAT, it is not mandatory.

The SPDAT can be completed as part of one conversation in the intake process, or through a series of visits in the early stages of the relationship. For some clients with complex needs, it may be necessary to have several conversations (sometimes in the form of multiple brief conversations) to gather enough accurate information to complete the tool. If you are uncertain of the accuracy of information received from the client, it is encouraged that you repeat the conversation to get clarity.

A guide is included at the end of this document to assist with communication when a conversational approach is used to gain information for completing the SPDAT. The conversation guide comes from practitioners with direct experience in administering the tool.

Using the SPDAT in Providing and Helping to Guide Supports

For those clients who are provided case management or other supports as a result of their SPDAT score, the SPDAT has proven to have great value in helping to guide case planning and support conversations.

Focusing attention on those areas of the SPDAT where the client has higher acuity has been successful in helping clients work through the Stages of Change (Prochaska & DiClemente). It has also proven to be helpful to case managers and other supports in guiding the conversation in client follow up, as well as in establishing objectives for each follow-up visit. Throughout its use, the SPDAT remains a tool that is client-centered and allows for strength-based approaches to service delivery.

Noting Discrepancies

With many clients you will gather information or observe behavior that may be contradictory to their self-assessment. This can be a positive aspect of case management process when working towards change. Do not shy away from being transparent in your assessment, noting the discrepancies whenever they appear.

Components of the SPDAT

The SPDAT is divided into 15 components (A to O below). Each component has a description that categorizes the scoring relative to each component.

The scoring begins with "0" that indicates higher functioning/non-issue. Level "4" indicates a more serious issue/situation. While a description is provided for each component complete with definitions, it is useful to include specific client examples in conjunction with each score. Certain scenarios require careful consideration about which score to use when the scenario does not precisely match the descriptions. In these instances, it is important for staff to provide their rationale for the score indicated.

For each component, there is an opportunity to record what you observed or the comments that the client disclosed that resulted in the score.

COMPONENT A

Self-Care and Daily Living Skills

A. Self Care and Daily Living Skills

This component is concerned with the functions of taking care of oneself, meeting daily needs independently, and living autonomously. Behaviours of interest here include such things as taking care of one's own personal hygiene, as well as being able to cook, clean, and do laundry.

This component also gives consideration to those individuals who are collectors or hoarders. Crucial to this assessment is the degree to which they are aware that such behaviours are an issue that is negatively impacting their life.

Under the scoring scheme below, "lives independently" refers to the ability to live without permanent on-site supports. It does not include individuals living in couples or with roommates.

If the individual is homeless at the time of assessment the most that they can receive is a 2.

0 =	Takes care of self and meets all daily living needs independently & lives independently.
1 =	Takes care of self and meets all daily living needs by infrequently accessing other community resources as needed.
2 =	Attempts to take care of self and meet all daily living needs, but has a few areas where assistance is sometimes required; may not be living independently (staying in a shelter).
3 =	Not always taking care of self and/or not always aware of what needs to be done to take care of self or daily needs; can require prompts; requires frequent assistance; may excessively acquire belongings (hoard or collect) but is aware that it is an issue.
4 =	Not taking care of self or meeting daily needs; often unaware and almost always needs prompts; requires intensive, frequent assistance; may excessively acquire belongings (hoard or collect) but is not fully aware or is not at all aware that it is an issue.

COMPONENT B

Social Relationships & Networks

B. Social Relationships and Networks

This component is concerned with social relationships and networks. Covered in this component is the client's engagement with friends and family, and to some degree their interaction and relationships with professionals.

There is no quantifiable measure of how many friends or family members a client should have, or the level of interaction that determines a relationship. More than one relationship involving fairly frequent interaction over several months is encouraged.

In some instances, the capacity of an individual to trust or make an informed decision

about social interaction can be a cause for concern. This is especially true of those clients who have a history of victimization, engagement in dependent relationships, and who are exploited for goods or services.

It is possible for a client to be satisfied with a relationship that is in fact detrimental to their own wellness. These types of situations are captured as a 4 on the scoring scale.

0 =	Has friends and/or family supports as they would like them, and has maintained those relationships for greater than 6 months.
1 =	Has some friends and/or family supports, and/or working on relationships, and/or the relationship is how they would like, but for less than 6 months.
2 =	Engaged in relationships with friends and/or family, occasionally with some difficulties and/or still at the very early stages of relationship development.
3 =	Discussing or is in the early stages of establishing relationships with friends and/or family, but having difficulty maintaining contact or advancing the relationship; or client has relationship with friends or family but it is have some negative consequences on the client's wellness. May be talking to new people, but not at a stage of trusting or liking them yet. Meanwhile, the individual may maintain good relationships with professionals.
4 =	While may have acquaintances or relationships with people out of convenience or necessity – including co-dependent relationships or feelings of need for the relationship based upon past victimization or abuse, no meaningful social relationships and networks with people of their choosing that they like; or client has relationship with friends or family but it is having serious consequences on the client's wellness. While the individual may have relationships with professionals, they are not consistently good.

C. Meaningful Daily Activity

COMPONENT C
Meaningful Daily Activity

This component is concerned with the ways in which clients spend their days. The activities that a client engages in are informed by their own choices. These activities should extend beyond those pursuits that are informed solely by the requirements of the case plan. Meaningful daily activities should provide engagement for most, if not all, days of the week.

Examples of activities that are not considered to be meaningful daily activities include using substances for large portions of the day and/or spending large portions of the day finding/getting money to pay for substances and/or sleeping or being otherwise incapacitated as a result of their substance use and/or acquiring substances; survival activities (e.g., binning; bottle collecting; sex work); therapy; doctor's appointments and medical treat-

One's choice of meaningful daily activity is informed by personal and cultural preferences, as well as financial capacities. Of importance is not only that the client is engaged in

meaningful daily activities, but that they also have a sense of fulfillment on some level from the participation in that activity. This usually is equated with intellectual, emotional, social, physical or spiritual fulfillment.

In addition, the activities and the sense of fulfillment should provide a sense of personal satisfaction. There is no specific metric for this satisfaction other than a personal feeling of self-esteem, contentment, confidence, recovery, etc.

While it is reasonable for an individual to enjoy solitary meaningful daily activities, there is an expectation that some activities will involve interacting with the community outside of their immediate housing situation.

0 =	Has activities related to employment, volunteering, socio-recreation, etc. that provide fulfillment intellectually, socially, physically, emotionally, spiritually, etc., occupying most times of day and most days of the week, and which provide a high degree of personal satisfaction.
1 =	Has some activities related to employment, volunteering, socio-recreation, etc. that provide some fulfillment intellectually, socially, physically, emotionally, spiritually, etc., occupying some times of the day and/or some days of the week, which provide a good degree of personal satisfaction.
2 =	Attempting activities that may provide fulfillment intellectually, socially, physically, emotionally, spiritually, etc. but not occupying most days or most parts of any given day, and not yet providing a good degree of personal satisfaction.
3 =	Discussing or in early stages of attempting activities that may provide fulfillment intellectually, socially, physically, emotionally, spiritually, etc. but not fully committed. At times disengaged from activities, and activities are not yet occupying most days, nor providing personal satisfaction.
4 =	Not engaged in any meaningful daily activities that provide fulfillment intellectually, socially, physically, emotionally, spiritually, etc. Very little to no personal satisfaction.

COMPONENT D

Personal Administration & Money Management

D. Personal Administration and Money Management

This component is concerned with a client's ability to manage their money and the associated administrative tasks such as paying bills, filling out forms, completing a budget, and submitting necessary paperwork or documentation.

Income sources should be considered formal (for example, employment income; income support through welfare, etc.) as well as informal (for example, proceeds from sex work; "working under the table"; drug sales, etc.).

that they manage that small amount of income quite well, but still run out of money towards the end of the month in most, if not all, months. This shortfall of funds is not an issue with their ability. It is an issue with the amount of money they receive relative to their other expenses such as housing. These individuals are classified as a 2.

0 =	Has an income source and manages all personal finances and benefits independently. Can pay bills and fill out all appropriate paperwork and forms without assistance from others. Has been doing so for 6 months or more.
1 =	Has an income source and manages all personal finances and benefits independently, and can pay bills, and fill out all appropriate paperwork and forms without assistance from others. Has been doing so for less than 6 months.
2 =	Has an income source and manages most personal finances and benefits with a little help from time to time, which may include help paying bills, filling out paperwork and forms or using a voluntary trusteeship program. Also includes those individuals that manage their money well with what they receive but require assistance from the likes of a food bank at the end of the month to make ends meet, as well as those that are on and off income support more than 2 times in any 12 month period.
3 =	Has an income source, but requires frequent assistance to manage personal finance and benefits, which may include the use of a guardian or trustee (which may be voluntary). Likely requires intensive supports to take care of paperwork and forms. Likely requires prompts, reminders and/or assistance paying bills and may not always budget appropriately for all bills. Likely requires intensive assistance budgeting. If a substance user, is likely not involved in accounting for substance use in budgeting. May have significant debt load, including "street debts" and/or gambling debts.
4 =	May or may not have an income. Requires intensive assistance with personal finances and benefits, which may include the use of a guardian or trustee (which may be voluntary). Almost always fails to appropriately fill out forms or complete paperwork. Cannot create or follow a monthly budget. Almost always needs prompts, reminders and/or assistance paying bills and almost always does not have enough income to cover all bills from the previous month (and may not comprehend this, thinking bills are consistently higher than they should be). Most likely not budgeting for substance use, if a substance user. Likely to have significant debt, including "street debts" and/or gambling debts.

COMPONENT E
Managing Tenancy

E. Managing Tenancy

This component is concerned with an individual's management of their apartment. The primary foci are payment of rent, not disrupting the enjoyment of other tenants, positive relations with the landlord/superintendent and avoiding unit damage.

Any person who is homeless at the time the SPDAT is completed shall be considered a 4.

This component is specifically concerned with the retention and implementation of skills necessary to care for one's apartment and manage their tenancy.

Third party payment of rent is not considered to be assistance in the payment of rent. That is an administrative function of how rent gets paid (not unlike a direct transfer for a mortgage payment), and not necessarily an indication of need for assistance.

0 =	Has taken care of apartment unit for 6 months or more without any external support including such things as payment of rent, following lease agreement and physically maintaining unit in good shape.
1 =	Has taken care of apartment unit for less than 6 months without any external support including such things as payment of rent, following lease agreement and physically maintaining unit in good shape.
2 =	Needs assistance in taking care of the apartment unit up to three times in any three month period or a maximum of once per month, which may include assistance paying rent, managing situations that the landlord has taken exception to, or in physically maintaining the unit in good shape. Has not needed to be re-housed within the past three months.
3 =	Needs assistance in taking care of the unit four to nine times in any three month period or two or more times per month, which may include assistance paying rent, conflict resolution and problem solving and mediation with the landlord, or in physically maintaining the unit in good shape. Has been re-housed as a result of these or similar issues within the past three months or will likely need to be re-housed within the next two months.
4 =	Needs assistance taking care of the unit ten or more times in any three month period or three or more times in any given month, which may include assistance paying rent, conflict resolution and problem solving and mediation with the landlord, or in physically maintaining the unit in good shape. Will need to be re-housed imminently or the re-housing process may be underway. This category also includes all clients that are not yet housed at time of baseline evaluation.

F. Physical Health and Wellness

This component covers physical health and wellness.

There are four considerations related to the client in this component: whether they have a physical health issue; the severity of the health issue; whether they are accessing care for that physical health issue (including those who may wish to access care but are unable to based upon insufficient health resources in the community); and, how the individual views wellness.

In this component, minor physical health issues are those that can be treated without overly intensive care or through non-obtrusive, accessible interventions. For example, an individual who breaks their arm and requires a cast, but does not require surgery or extensive physiotherapy may be considered to have a minor physical health issue. Another example might include an individual with an arthritic knee who routinely uses a mobility-assistance device.

Chronic health issues include, but are not limited to, conditions such as heart disease, cancer, diabetes, and immunological disorders.

Intensive health supports includes the provision of professional wound care, assistance with a colostomy bag, injection medications and similar interventions.

	No physical health issues. Completely well.
1 =	Physical health issues are relatively minor, or in the event of a chronic condition, the individual has considerable knowledge of their health needs and closely follows the treatment protocol. The individual is connected to appropriate professional resources.
2 =	Physical health issues present and while the individual is following treatment protocols, day to day functioning is still impacted.
3 =	Physical health issues present, which may be chronic in nature and/or requires intensive health supports, but the individual is not connected to appropriate professional resources either by choice or because of insufficient community resources. In some limited situations an individual may be connected to supports and following treatment protocols, but the treatment is having very little to no impact on improving day to day living and/or the individual cannot follow all parts of the treatment protocol (e.g., required to rest, but no place to rest 24/7 because of being homeless). The individual may not see the total value of wellness and getting better.
4 =	Serious health issues which are most frequently co-occurring, chronic and complex. In most instances the individual is not connected to appropriate professional resources, or the individual is involved in treatment that is having no impact on the condition and/or the individual cannot implement the treatment protocol; and/or, the individual is palliative.

COMPONENT G

Mental Health & Wellness & Cognitive Functioning

G. Mental Health and Wellness & Cognitive Functioning

This component covers mental health and wellness, as well as cognitive functioning. The intent is not to provide a diagnosis. While there may be many reasons for an individual to have a compromised ability to communicate clearly or engage in socially appropriate behaviour, these may be clues, along with the likes of delusions, hallucinations, incomprehensible dialogue, or apparent disconnect from reality. A suspected or untrained observation of mental illness or compromised cognitive functioning can be a prompt for further dialogue to have an appropriate professional engage.

There are a range of mental health conditions. Consideration should be given to any individual who would fall under Axis I, II or III disorders according to the DSM-IV (Diagnostic and Statistical Manual).

An Axis I disorder covers clinical disorders including major mental disorders and learning disorders. An Axis II disorder covers retardation of mental capacity and personality disorders. An Axis III disorder covers acute medical conditions or physical disabilities such as brain injuries that aggravate existing symptoms or can present symptoms similar to other disorders.

Caution should be exercised in considering whether an individual qualities as having a serious and persistent mental illness. Some considerations in making this determination would include such things as: whether they have been hospitalized for psychiatric care two or more times in the last two years; whether they have an Axis I or Axis II disorder; and, whether it is reasonable to believe they would likely be hospitalized for psychiatric care according to a mental health professional.

Included in consideration of compromised cognitive functioning are barriers to daily functioning that result from the likes of head injuries, learning disabilities (as validated by neuropsychological or psycho-educational testing), and/or developmental disorders. In most instances barriers to daily functioning as a result of compromised cognitive functioning will include one or more of the following: diminished aptitude; issues with memory especially related to visual or verbal acquisition, retrieval, retention and/or recognition; attention issues such as decreased visual or auditory spans of attention; compromised executive functioning such as the ability to plan, prioritize, organize or sequence activities.

0 =	No mental health or cognitive functioning issues disclosed, suspected or observed.
1 =	The individual has disclosed that they have a mental health issue or diminished cognitive functioning, and are effectively engaged with professional assistance to manage the issue; or an individual is in a heightened state of recovery, fully aware of their symptoms and wellness and manages their mental health and wellness independently.
2 =	The individual has a disclosed, suspected or possibility of mental health issues and/or cognitive functioning issues based upon that which is observed or heard, but any impact on communication, daily living, social relationships, etc is minimal. Possibly without formal diagnosis. If diagnosed, may not require anything more than infrequent assistance.
3 =	The individual has a significant mental health issue disclosed, suspected or observed, or the individual has significantly diminished cognitive functions, most likely having an impact on communication, daily living, social relationships, etc. The individual may have supports but the mental health and/or cognitive functioning issues still have considerable impact on day-to-day living. Assistance is required, but the client has no consistent, ongoing assistance.
4 =	The individual has a serious and persistent mental health issue disclosed, suspected or observed and/or the individual has major barriers to daily functioning as a result of compromised cognitive functioning; most likely greatly impacting communication, daily living, social relationships, etc., While most often without ongoing assistance, it is possible that the individual does have supports, but their serious and persistent mental health issues or major cognitive functioning issues are still greatly impacting day to day living.

COMPONENT H

Medication

H. Medication

This component addresses medications that have been prescribed by a professional and that are being used in an amount and for a purpose that is consistent with the prescription.

Over the counter medications are not included here. If a client is using an over the counter medication for a purpose other than intended, it may be considered as part of the component on substance use.

Those who take medications that are not prescribed by a medical professional, even if it is for a mental health or physical ailment, should be considered substance use.

0 =	Does not take any medications, or has demonstrated consistent self-management of medications for greater than 6 months.
1 =	Takes medications and has been self-managing the use of medications for less than 6 months.
2 =	Takes medications but requires some assistance from time to time, including prompts to take the medication, understanding what the medication is for and/or instruction on proper storage or use of the medication.
3 =	The individual takes medications, but may forget to take them regularly or may use them improperly from time to time. If the individual is selling their prescription drugs to others, they keep the majority of the prescription for themselves. Likely requires significant assistance to manage, including regular reminders, schedules or prompts, understanding what the medication is for and/or instruction on proper storage or use of the medication. May also include individuals who have had their prescription changed within the past month and the effects and routine of the new regime are not yet fully worked out, but are not having a debilitating impact on the person's health or daily activities.
4 =	The individual does not use medications as prescribed, which may include frequently failing to take the medication. This includes individuals with a prescription that is never filled (including those who did not fill the prescription because of financial restraints). If the individual is selling their prescription drugs, most or all of the prescription is sold. The individual may also demonstrate a lack of interest or understanding in how and when to take the medication, what it is for, or how it should be stored or used. May also include individuals who have had their prescription changed within the past month and the effects and routine of the new medication are significantly impacting day-to-day living, their health or daily activities.

I. Interaction with Emergency Services

COMPONENT I

Interaction with Emergency Services

This component is concerned with interactions with emergency services.

An interaction is not a casual encounter such as striking up a conversation with a police officer on the street, passing by a firefighter battling a blaze, seeing ambulance workers provide care on the street, or taking a friend to the emergency room. The interactions this component is interested in are deliberate and direct interactions between the client and staff from emergency rooms in hospitals, police officers, ambulance attendants and/or fire-fighters (including in the capacity of providing First Aid/CPR – not solely in their function of fighting fire).

Also relevant to this component is the client's interaction with crisis services, and their time spent in hospitals for overnight or long term care.

0 =	No interaction with emergency rooms, hospital, crisis service, police, ambulance or fire for more than 6 months.
1 =	No interaction with emergency rooms, hospital, crisis service, police, ambulance or fire for less than 6 months.
2 =	One to three interactions with emergency rooms, hospital, crisis service, police, ambulance and/or fire in the last 6 months.
3 =	Four to nine interactions with emergency rooms, hospital, crisis service, police, ambulance and/or fire in the last 6 months.
4 =	Ten or more interactions with emergency rooms, hospital, crisis service, police, ambulance and/or fire in the last 6 months.

J. Involvement in High Risk and/or Exploitive Situations

COMPONENT J

and/or Exploitive Situations

This component is concerned with a client's involvement in high risk and/or exploitive situations.

Involvement on the part of the client may have been voluntary or involuntary. It is both what they have done as well as what has been done unto them.

While not an exhaustive list, examples of high risk and exploitive situations include: sex work; injection substance use; slavery; drug mule; unprotected sexual engagement (outside of a monogamous relationship); binge drinking; sleeping outside as a result of blacking out; being directly or indirectly forced to work; being used for any activity against one's will, consent or knowledge; being short-changed for work undertaken; being in environments prone to violence; engaging in activity solely for the benefit of others without any personal gain or benefit.

This component also includes those individuals leaving an abusive situation given the high risk the abuser presents. As the mental or physical abuse experienced by the victims is a daily occurrence, these victims are considered a 4.

People who have been sleeping rough may also be considered to be in a high-risk situation. Without protective clothing and appropriate sleeping gear they run the risk of exposure and temperature related ailments. Depending on where they are sleeping rough, they may be exposed to higher incidents of violence, sexual assault, and theft.

0 =	Has not been involved in a high risk or exploitive situation for more than 6 months.
1 =	Has not been involved in a high risk or exploitive situation for less than 6 months.
2 =	Has been involved in one to three high risk or exploitive situations in the last 6 months.
3 =	Has been involved in four to nine high risk or exploitive situations in the last 6 months.
4 =	Has been involved in ten or more high risk or exploitive situations in the last 6 months.

COMPONENT K

Substance Use

K. Substance Use

This component covers substance use, which is the use of alcohol (including non-palatable alcohol) and/or other drugs.

Prescription drugs, including methadone treatment, are not considered in this component unless they are used for a purpose other than for how they were prescribed. Otherwise, they are considered in the component on medication.

Information on usage thresholds has been drawn from leading addiction scholars and researchers. It is acknowledged that there can be differences in opinion amongst learned professionals in this field concerning the distinction between substance use and abuse, and in the amounts that can be safely consumed on a daily or weekly basis. "Acceptable consumption thresholds" for alcohol are: 2 drinks per day or 14 total drinks in any one week period for men; 2 drinks per day or 9 total drinks in any one week period for women.

Non-palatable alcohol includes any substance with an alcohol content that is not intended for sipping or regular consumption. This would include substances such as Listerine, cooking wine and alcohol based hand-sanitizers.

Binge drinking is classified as any instance where a male consumes 5 or more drinks or a female consumes 4 or more drinks in a single hour; or when 10 or more drinks are consumed in a single drinking episode (for example, an evening of drinking).

0 =	Has not used drugs or alcohol for 12 months or more.
1 =	Does not use drugs. Alcohol consumption does not exceed acceptable consumption thresholds. Substance use has no impact on daily functioning. If practicing abstinence, has achieved at least 14 days of sobriety.
2 =	Up to four incidents of using drugs and/or alcohol in a one month period, that may occasionally include non-palatable alcohol, and/or may occasionally include binge drinking. Any impact that the substance use has on daily functioning is infrequent. If there are health impacts as a result of substance use, the impacts are relatively minor.
3 =	More than four incidents of using drugs and/or alcohol in a one month period, that may include non-palatable alcohol, may include binge drinking, and is likely to exceed daily maximum acceptable consumption thresholds on a regular basis. Impacts of the substance use on daily functioning are frequent, even if the individual does not acknowledge these consequences. Health is likely compromised as a result of alcohol or drugs.
4 =	Use of drugs and/or alcohol is likely daily, frequently including non-palatable alcohol, most often including binge drinking, most often using to the point of complete inebriation (may include passing out). Impacts of the substance use on daily functioning are severe and may be life threatening.

COMPONENT L

Abuse and/or Trauma

L. Abuse and/or Trauma

This component is concerned with the impact of abuse or trauma experienced by the individual, including inter-generational impacts. Included in this component are individuals who are survivors of abuse or trauma as children. Additionally, traumatic events may be very recent or ongoing, and may be the cause of the current period of homelessness. Note that the experience is not automatically considered to be a traumatic event for all people.

For the purpose of this component institutional abuse is considered a history of abuse or trauma.

This component uses self-reports to assess the impact of abusive and traumatic experiences on day-to-day life, and to assess the state of recovery, if any. The purpose of this component is not to uncover what the traumatic events were/are, and care must be exercised to avoid exploring the traumatization through questioning.

In recognition that not all have access to professional counseling services, therapeutic recovery should considered broadly. This is particularly pertinent when considering culturally significant healing practices.

0 =	The individual does not report a past or present experience of abuse and/or trauma.
1 =	The individual has a history of abuse and/or traumatic events, but reports no serious consequences on present functioning and/or ability, or indicates resolution of past abuse through therapeutic means.
2 =	The individual has a history of abuse and/or traumatic events that are impacting present functioning and/or ability. The individual may currently be engaged in therapeutic attempts at recovery, but does not consider self to be recovered.
3 =	The individual has a history of abuse and/or traumatic events that are severely impacting present functioning and/or ability. The individual has not attempted therapeutic recovery.
4 =	The individual is currently experiencing abuse or a traumatic event that is causing the current period of homelessness. No attempt at therapeutic recovery has been made.

COMPONENT M

Risk of Personal Harm/ Hatrm to Others

M. Risk of Personal Harm/Harm to Others

This component is concerned with risk of personal harm and/or risk to others.

Included in this component are both actions and written or verbal statements. That is, the undertaking of harm as well as the threatening of harm.

There are no guaranteed ways in which someone can predict if another person will act in ways harmful to themselves or others.

The assessment for this component takes into consideration the likelihood of risk which considers a number of indicators, the history of harming oneself or others, the time since the last action or threats, and, the individuals ability to de-escalate.

The indicators that help inform the likelihood or risk include such things as:

- Severe depression
- Giving away personal possessions
- Expressing plans for a suicide attempt
- Sense of hopelessness
- Access to lethal means such as a weapon or toxic substance
- Previous suicide attempts
- Excessive substance use
- Social withdrawal and isolation
- History of incarceration for violent acts
- Specific threats of violence against specific people
- Strong feelings of being wronged by a specific person or group of people
- Expressing plans for a violent act against another person or group of people

0 =	No perceived risk to self or others. No known history of harming self or others. No known threats or making of harmful statements.
1 =	Limited risk to self or others. No history of harming self or others within the past 12 months, though may have limited exposure from the past. No threats or making of harmful statements within the past 6 months.
2 =	Possible risk to self or others. No history of harming self or others within past 12 months, though may have exposure from the past. May have very infrequently made statements concerning potential harm to self or others within the past 6 months, but no action taken. Individual de-escalated after making statements.
3 =	Probable risk to self or others. Episode of attempting or actually harming self or others within past 12 months and likely verbal or written statements threatening harm to self or others within the past 6 months.
4 =	Imminent risk to self or others. Clear, strong threats of harming self or others, without de-escalation. Recent frequent episodes of attempting or actually harming self or others.

N. Legal

COMPONENT N

Legal

This component is concerned with legal issues.

Legal issues pertain to any offences by any order of government or any area of law enforcement to which the person is subject to such things as paying a fine, undertaking community service, or being incarcerated.

Unless it is a single individual involved in such matters, it does not include any involvement in family court or child custody apprehension, as these are dealt with in a separate component.

The time frames references below pertain to the length of time since the most recent court appearance (not the time since the charge which may have occurred quite a bit of time before).

0 =	No legal issues for 12 months or more.
1 =	At least one legal issue in the past 12 months, but it was discharged or resolved without community service, payment of fine or incarceration. No current legal issues.
2 =	At least one legal issue in the past 12 months and it was resolved through payment of fine or community service. It may also include current legal issues that are unlikely to result in loss of housing or incarceration.
3 =	At least one legal issue in the past 12 months that may result in fines that may put housing at risk and/or periods of incarceration of three months or less that may place housing at risk.
4 =	At least one legal issue in the past 12 months that resulted in fines that place housing at imminent risk and/or periods of incarceration greater than three months.

COMPONENT O

History of Homelessness & Housing

O. History of Homelessness and Housing

This component is concerned with the client's history of homelessness and housing.

The cumulative duration of homelessness is concerned with the total number of days that a person was homeless within the specified time period. It acknowledges that a person may have been homeless for one or two days, housed, then homeless again. The number of days spent homeless is added up to produce the cumulative total.

The types of homelessness captured in this section include absolute homelessness (sleeping rough; staying in shelters; living in a car; squatting) as well as relative homelessness (couch surfing; overcrowding). What is most important is the client's own determination of what constituted their homelessness. Prompts may be necessary to assist clients in making a determination of when they considered themselves to be housed or homeless.

This component will not change in later assessments of the SPDAT unless the client reveals new information.

0 =	years, which may include being recently re-housed.
1 =	Cumulative duration of homelessness was between 8 and 30 days over the past four years, which may include being recently re-housed.
2 =	Cumulative duration of homelessness was between 30 days and 2 years over the past four years.
3 =	Cumulative duration of homelessness was between 2 years and 5 years over the past decade.
4 =	Cumulative duration of homelessness was greater than 5 years over the past decade.

Summarizing Scores

It is recommended that Frontline Workers, Team Leaders and Program Supervisors build familiarity with the descriptions of all of the components above. The objective is to achieve competence in applying the SPDAT without having to reference the complete SPDAT Manual. The most important tool is the Summary Sheet on the next page. The Summary Sheet should be the only documentation visible to the client when using a conversational approach to gaining input for the SPDAT. As previously noted in the section about disclosure, the client should be offered a copy of the Summary Sheet after the application of each SPDAT.

In the event of uncertainty between two possible scores for a component, i.e., if you are uncertain if the client is a "2" or a "3", the higher score should be used.

The Comments section should be used throughout the Summary Sheet for five fundamental reasons:

1. The Comments section should reveal the source of the information that led to the assessment: Self-Report, Observation, Case Notes, Conversation, Other Documentation.
2. The Comments section should be used to note if there was uncertainty and a higher score for the component was used—as noted above.
3. The Comments section can be used to note if any particular circumstances seem to be impacting the assessment score for an individual component.
4. The Comments section can be used to make note of any relevant trends in the component for the client.
5. The Comments section can be used to make any notes that will be helpful for subsequent SPDAT evaluations.

Practitioners should write comments factually. Comments should only be relevant to the context of the SPDAT and mindful of the fact that clients will be offered a copy of the SPDAT Summary Sheet.

When summarizing the scores, it is important that a score is noted for every component. For example, noting a "0" is appropriate, leaving the component blank with an implied "0" is not appropriate. After there is a value for each component, a total score can be tallied for the client. This final score represents the client's level of acuity out of a total possible rating of 60.

SPDAT SUMMARY

Client: _____

Worker: _____

Date: _____

Component	Assessment (0, 1, 2, 3 or 4)	Comments
A. Self Care and Daily Living Skills		
B. Social Relationships and Networks		
C. Meaningful Daily Activity		
D. Personal Administration and Money Management		
E. Managing Tenancy		
F. Physical Health and Wellness		
G. Mental Health and Wellness		

Component	Assessment (0, 1, 2, 3 or 4)	Comments
I. Interaction with Emergency Services		
J. Involvement in High Risk and/or Exploitive Situations		
K. Substance Use		
L. Abuse and/or Trauma		
M. Risk of Personal Harm/ Harm to Others		
N. Legal		
O. History of Homelessness and Housing		
TOTAL		

Prioritizing Service Based Upon Score & Guiding Supports

The recommended intervention and approach to supports is linked to the level of acuity.

Scoring Range	Intervention	Comments
	Housing Help Supports	Generally high functioning individuals with shorter periods of homelessness. Needs are not as complex in most of the SPDAT categories. Are most likely to solve their own homelessness, perhaps with very brief financial assistance, shallow subsidy, access to apartment listings and the like.
20-39	Rapid Re-housing	With some supports, though not as intensive as Housing First, the individuals can access and maintain housing. The focus of the supports will more likely be on a smaller number of SPDAT components. Support services do not last as long as Housing First supports.
40-60	Housing First	These are individuals with more complex needs who are likely to benefit from case management supports either through Intensive Case Management or Assertive Community Treatment. Scores in the SPDAT are likely to be higher (3s and 4s) in many of the components.

Within each category, those clients scoring closer to the top of the threshold are the first priority. For example, if two clients have undergone an intake and one scores a 53 and the other a 49, and there is only one opening on a caseload, the individual with the highest score is served first.

For those clients who receive a Rapid Re-housing or Housing First service, it is expected that the overall SPDAT score is likely to decline over time during the period when a client is receiving supports even though there may be fluctuations in any of the 15 elements from one review to the next.

Consistently lower scores (which reflects overall life improvements and increased stability) can be used to focus on "graduation" from program supports, leading to decreased and then terminated service supports.

If a client is in crisis at the time of an SPDAT measurement, it may misrepresent overall acuity. To provide greater accuracy in the overall measurement, it is recommended that an additional SPDAT evaluation be taken once the crisis is resolved.

Regardless of the scoring and priority sequencing system outlined above, circumstances may that require additional information be considered in establishing the priority of clients to be served. This decision rests with the Team Leader and/or Senior Managers/Central Administrators within the community. It is incumbent upon these decision makers to justify exceptions in service delivery, acknowledging that there can be many reasons for an exception based upon local circumstances at any point in time. Known as the "notwithstanding" clause of SPDAT use, it is important that this approach is used infrequently, in limited circumstances and with sufficient justification.

System Navigation and Support for Clients Can Be Informed Using SPDAT Results

Individual communities as well as cross-agency partnerships can create specific processes to better assist clients relative to their SPDAT score.

For example, a SPDAT score of 52+ that includes higher scores related to mental health and wellness and/or physical health and/or substance use may trigger a referral or secondary assessment by a specialized health, mental health or addiction resource such as an ACT Team or another specialized service team.

Within individual teams, Team Leaders can use the SPDAT scores in each component to help inform which Follow-up Support Worker may have a skill set or expertise to best assist with a specific circumstance. The assigning of a Follow-up Support Worker to a particular client can be rationalized using SPDAT information.

There may also be instances where SPDAT scores are employed to enhance inter-agency partnership or overall caseload balance throughout the service system. For example, Team Leader and/or Senior Management meetings across agencies may result in client transfers among Housing First teams to ensure more balance across teams of clients with higher SPDAT scores.

Local Variations in SPDAT Use

Locally, system administrators can develop their own rules pertaining to priorities from scoring, system navigation, integration with a Homeless Management Information System and the use of the notwithstanding clause.

Individual organizations and communities may not adjust the scoring, ranking or descriptions of any of the 15 components.

Guide to Assist SPDAT Conversation

As noted previously, much of the information for completing the SPDAT can be attained through methods other than a specific conversation about the components. For example, a home visit with a client may self-reveal that they are not managing their medications. This information is used for the SPDAT rather than seeking the information again—unless there

was confusion about the client's intent. Another example might be a client who shares some legal documentation that provides information relative to understanding how to complete the Legal category of the SPDAT. Information may also be obtained for the SPDAT through observation. Home visits are opportunities to assess the components Self Care and Daily Living Skills and/or Managing Tenancy.

The SPDAT is also integrated with information from the support and case planning process. Conversations with clients relative to their goals and activities often provide sufficient information for the assessment of many of the other components. Information obtained through the support and case planning process does not need to be repeated during the SPDAT assessment unless clarification is required.

When a specific conversation about the SPDAT is needed, the following questions can be helpful in guiding and assisting with that conversation. These questions have worked well during implementation of versions one and two of the SPDAT. To improve implementation, we encourage organizations within each community to share the questions that they are using to gain information from clients.

The following table outlines questions that will guide and assist the conversation. These questions are suggestions, and are not mandatory to achieve responses for the SPDAT. The questions are organized by SPDAT components:

Component	Probing Question(s):
A. Self Care and Daily Living Skills	• Do you have any worries about taking care of yourself? • Do you have any concerns about looking after cooking, cleaning, laundry or anything like that? • Do you ever need reminders to do things like shower or clean up? • If I were to come over to your last apartment, what would it look? • Do you know how to shop for nutritious food on a budget? • Do you know how to make low cost meals that can result in leftovers to freeze or save for another day? • Do you tend to keep all of your clothes clean? • Have you ever had a problem with mice or other bugs like cockroaches as a result of a dirty apartment? • When you have had a place where you have made a meal, do you tend to clean up dishes and the like before they get crusty?

Component	Probing Question(s):
B. Meaningful Daily Activity	• How do you spend your day? • How do your spend your free time? • Does that make you feel happy/fulfilled? • How many days a week would you say you have things to do that make you feel happy/fulfilled? • How much time in a week would you say that you are totally bored? • When you wake up in the morning do you tend to have an idea of what you plan to do that day? • How much time in a week would you say you spend doing stuff to fill up the time rather than doing things that you love? • Are there any things that get in the way of you doing the sorts of activities you would like to be doing?
C. Social Relationships and Networks	• Tell me about your friends, family and the other people in your life. • How often do you get together or chat with these people? • When you go to doctors appointments or meet with other professionals like that, what is that like for you? • Are there any people in your life that you feel are just using you? • Have you ever been threatened with an eviction or lost a place because of something that friends or family did in your apartment? • Are there any of your closer friends that you feel or always asking you for money, smokes, drugs, food or anything like that? • Have you ever had people crash at your place that you did not want staying there? • Have you ever been concerned about not following your lease agreement because of your friends or family?

Component	Probing Question(s):
D. Mental Health and Wellness & Cognitive Functioning	• Have you ever received any help with your mental wellness? • Have you ever had a conversation with a psychiatrist or psychologist? When was that? • Do you feel you are getting all the help you might need with whatever mental health stress you might have in your life? • Have you ever hurt your brain/head? • When you were in school, did you ever have trouble learning or paying attention? Was any reason given to you for that? • Was there ever any special testing done on you when you were in school or as a kid? • Has any doctor ever prescribed you pills for your nerves, anxiety, feeling down or anything like that? • To the best of your knowledge, when your mother was pregnant with you did she do anything that we now know can have lasting effects on the baby? • Have you ever gone to an emergency room or stayed in a hospital because you weren't feeling 100% emotionally?
E. Physical Health and Wellness	• How is your health? • Are you getting any help with your health? How often? • Do you feel you are getting all the care you need for your health? • Anything like diabetes, HIV, Hep C or anything like that going on? • Ever had a doctor tell you that you have problems with your blood pressure or heart or lungs or anything like that? • When was the last time you saw a doctor? What was that for? • Do you have a clinic or doctor that you usually go to? • think would prevent you from living a full, healthy, happy life?

Component	Probing Question(s):
F. Substance Use	• Be straight up - when was the last time you had a drink or used drugs? • Is there anything we should keep in mind related to drugs or alcohol? • [If they disclose use of drugs and/or alcohol] How frequently would you say you use [specific substance] in a week? • In the last little while have you ever drank so much you passed out? • Ever get into fights when you drink? • Ever have a doctor tell you that your health may be at risk in any way when you drink or use drugs? • Ever fall down and bang your head when drinking or using other drugs? • Have you ever used alcohol or other drugs in a way that may be considered less safe? • Do you ever end up doing things you later regret after you have tied one on? • Do you ever drink the likes of mouthwash or cooking wine or hand sanitizer or anything like that? • When you use drugs, in the last year have you ever had bad stuff that made you feel off?
G. Medication	• Do you take any medicines? • [If they do] Were these prescribed by a doctor? To you? • Have you ever sold some or all of your prescription? • Have you ever had a doctor prescribe you a medicine that you didn't have filled at a pharmacy or didn't take? • Were any of your medicines changed in the last month? How did that make you feel? • Do other people ever steal your medicine? • Tell me about how you store your medicine and make sure you take the right medication at the right time each day.

Component	Probing Question(s):
H. Personal A dministration and Money Management	• How are you with taking care of money? • How are you with paying bills on time and taking care of other financial stuff? • Do you have any street debts? • Do you have any drug or gambling debts? • Is there anybody that thinks you owe them money? • Do you budget every single month for every single thing you need? Including cigarettes? Booze? Drugs? • Do you try to pay your rent before paying for anything else? • Are you behind in any payments like child support or student loans or anything like that?
I. Abuse and/or Trauma	• I don't need you to go into any details that you are not comfortable with, but has there been any point in your life where you experience emotional, physical, sexual or psychological abuse? • Are you currently or have you ever receiving professional assistance to address that abuse? • Does the experience of abuse or trauma impact your day to day living in any way? • Does the experience of abuse or trauma impact your ability to hold down a job, maintain housing or engage in meaningful relationships with friends or family? • Have you ever found yourself feeling or acting in a certain way that you think is caused by a history of abuse or trauma? • Is your most recent or any past episodes of homelessness a direct result of experiencing abuse or trauma?
J. Risk of Personal Harm/ Harm to Others	• Do you have thoughts about hurting yourself or anyone else? • Have you ever acted on these thoughts? • When was the last time? • What was occurring when you had these feelings or took these actions? • Have you ever received professional help – including maybe a stay at hospital – as a result of feeling or attempting to hurt yourself or others?

Component	Probing Question(s):
K. Interaction with Emergency Services	• How often do you go to emergency rooms? • How many times have you had the police speak to you over the past six months? • Have you used an ambulance or needed the fire department at any time in the past 6 months? • How many times have you called or visited a crises team or a crisis counsellor in the last 6 months? • How many times have you been admitted to hospital in the last 6 months? How long did you stay?
L. Involvement in High Risk and/or Exploitive Situations	• Does anybody force or trick you to do something that you don't want to do? • Do you ever do stuff that could be considered dangerous like drinking until you pass out outside or delivering drugs for someone or having sex without a condom with a casual partner? • Do you ever find yourself in situations that may be considered at a high risk for violence? • Do you ever sleep outside? Tell me about how you sleep? • Do you have any illnesses that may be passed on to others?
M. Legal	• Got any legal stuff going on? • Have you had a lawyer assigned to you by a court? • [If they do] Got any upcoming court dates? Do you think there's a chance you will do time? • Any involvement with family court or child custody matters? • Any outstanding fines? • Have you paid any fines in the last 12 months for anything? • Have you done any community service in the last 12 months? • Is anybody expecting you to do community service for anything right now? • Did you have any legal stuff in the last year that got dismissed? • Is your housing at risk in any way right now because of legal things?

Component	Probing Question(s):
N. History of Homelessness and Housing	How long have you been homeless? How many times have been homeless in your life other than this most recent time? Have you spent any time sleeping on a friend's couch or floor? And if so, during those times did you consider that to be your permanent address? Have you ever spent time sleeping in a car or alley way or garage or barn or bus shelter or anything like that? Have you ever spent time sleeping in an abandoned building? Were you ever in hospital or jail for a period of time when you didn't have a permanent address to go to when you got out?
O. Managing Tenancy	[For individuals who are housed] Do you think that your housing is at risk? How is your relationship with your neighbours? How have you been doing with taking care of your place?

Building Consistency Using SPDAT

The key to effectively and consistently using the SPDAT within a team and throughout a community is training, practice and sharing successes and mistakes.

Throughout a community of Housing Help, Rapid Re-housing and Housing First professionals, there should be a common understanding about each component of the SPDAT. It is common to most assessment tools for practitioners to have different perspectives about the score of a particular component. The sign of successful, consistent application of the SPDAT is when two people who have experience working with the same client in the same situation have SPDAT scores that vary by only a single point.

Staff members and organizations should not deviate from the current definitions or operational instructions for the SPDAT or create their own system. To ensure valid and reliable evaluation of outcomes, definitions and interpretations of information must be consistent within and across all organizations delivering Housing Help, Rapid Re-housing and Housing First within a community. Doing otherwise results in an inconsistent approach to prioritizing services and meeting the needs of clients. "Creaming" is unacceptable and counter-productive.

Infusing SPDAT into a standard practice will require the tool to be a part of the initial orientation or on-boarding new staff. Shadowing and coaching can be effective approaches for ensuring that new staff members apply the SPDAT consistently with other members of the team.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CHS Coordinated Assessment Consumer Survey

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CHS Coordinated Assessment Process Evaluation

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IN CASE OF EMERGENCY

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COMMUNITY HUMAN SERVICES CORPORATION
SUPPORTIVE OUTREACH TEAM
Job Description

PAP CODE:
POSITION #:
EEO CLASS:
WC CLASS:

POSITION: Director of Customer Service and Intake
REPORTS TO: CEO

I. FUNCTIONAL DEFINITION

The Director of Customer Service and Intake (DCSI) is responsible for making the application and service experience at CHS a positive one. The DCSI will work with the directors of the Homeless Assistance Programs, the Quality Committee and the CEO to create and operate a seamless and responsive intake protocol that respects the people served by CHS, ensures they receive assistance in a timely manner and oversees client data collection and entry.

The DCSI will recruit, train and supervise the consumer liaisons, data administrators and reception. The DCSI will be responsible for ensuring the entry point services are high functioning, support the work of the programs and deliver excellent customer care.

The DCSI will be responsible for collecting assessments, assisting the intake coordinators in determining program eligibility and program/case manager assignments for all homeless assistance and eviction prevention programs at SOT in conjunction with the program directors. S/he will oversee and assist in the process incoming applications and conduct an initial contact with the applicant to determine eligibility for the appropriate SOT program.

II. RESPONSIBILITIES/ DUTIES

The DCSI will:

1. Support the SOT programs' philosophy and goals.
2. Supervise Customer Service and Intake staff.
3. Identify appropriate procedures for various situations and participate in policy and procedure development with the other Program Directors and CEO.
4. Create a system for and maintain current intake information on all SOT clients.
5. Identify issues and recommend appropriate action to resolve problems.
6. Collaborate with other key community organizations in related areas.
7. Review incoming referrals, determine appropriateness for SOT programs, and assign to a SOT program.
8. Ensure that the Data Administrator receives all needed information for any database and HMIS on each SOT applicant.
9. Administrative oversight to ensure the program is in compliance with all reporting obligations to HUD including all program monitoring visits.
10. Determine appropriate referrals and program linkages.
11. Perform all other duties as assigned.

III. QUALIFICATIONS/ REQUIRED ABILITIES

1. BA/BS degree or any combination of life, work and educational experiences.
2. 3 Year Case Management/ Intake Experience
3. Crisis management skills
4. Supervisory skills
5. Strong organizational, communication and management skills.
6. Ability to manage multiple components of a project in various stages of completion.
7. Sensitivity toward individuals and families in need of program services.
8. Commitment to the project and the agency's mission.
9. Willingness to work collaboratively with staff and other organizations to achieve goals.
10. Advanced computer literacy.
11. A working knowledge of county social service system.
12. The ability to travel independently.

COMMUNITY HUMAN SERVICES CORPORATION
SUPPORTIVE OUTREACH TEAM
Job Description

PAP CODE:
POSITION #:
EEO CLASS:
WC CLASS:

POSITION: Intake Coordinator
REPORTS TO: Director of Customer Service and Intake

I. FUNCTIONAL DEFINITION

The Intake Coordinator will work in conjunction with the Program Director to ensure efficient assessment and program assignment procedures for all of the SOT's Homeless Assistance Programs. The focus of these programs is to create a continuum of care of homeless services to be provided to persons who are homeless, at risk of being homeless or experiencing other housing instability. The programs seek to empower consumers to secure and/or maintain permanent housing.

The Intake Coordinator is responsible for performing assessment and program/case manager assignments for all homeless assistance and eviction prevention programs at SOT. S/he will process incoming applications and conduct an initial contact with the applicant to determine eligibility for the appropriate SOT program. S/he will input data on each client into the electronic records data base to ensure client information can be tracked. S/he will act as the initial point of contact for all clients and respond to issues around their assignment into a SOT program until connected with the assigned case manager.

II. RESPONSIBILITIES/ DUTIES

The Intake Coordinator will:

1. Support the SOT programs' philosophy and goals.
2. Identify appropriate procedures for various situations and participate in policy and procedure development with the Program Director.
3. Maintain current intake information on all SOT clients.
4. Identify issues and recommend appropriate action to resolve problems.
5. Collaborate with other key community organizations in related areas.
6. Review incoming referrals, contact applicants, determine appropriateness for SOT programs, and assign to a SOT program with a case manager.
7. Ensure that the Data Administrator receives all needed information for any database and HMIS on each SOT applicant.
8. Administrative oversight to ensure the program is in compliance with all reporting obligations to HUD including all program monitoring visits.
9. Determine appropriate referrals and program linkages.
10. Perform all other duties as assigned.

III. QUALIFICATIONS/ REQUIRED ABILITIES

1. BA/BS degree or any combination of life, work and educational experiences.
2. 1 Year Case Management Experience
3. Strong organizational, communication and management skills.
4. Ability to manage multiple components of a project in various stages of completion.
5. Sensitivity toward individuals and families in need of program services.
6. Commitment to the project and the agency's mission.
7. Willingness to work collaboratively with staff and other organizations to achieve goals.
8. Basic computer literacy.
9. A working knowledge of county social service system.
10. The ability to travel independently.

COMMUNITY HUMAN SERVICES
SUPPORTIVE OUTREACH TEAM
Job Description

PAP CODE: SA-1
POSITION NO: 903
EEOC CLASS: 951
WC CLASS: 2

POSITION: Consumer Liaison
REPORTS TO: Director of Customer Service and Intake

I. FUNCTIONAL DEFINITION:

The Consumer Liaison will be the first service connection for families and individuals who will be participating in HUD and HAP housing programs. The focus of the projects is the creation of a service environment that fosters greater independence and the ability to bridge the gap from unstable or temporary housing to safe and affordable permanent housing.

The Consumer Liaison will be assisting the team with the intake and referral process, including but not limited to, making the first contact with potential participants, identifying appropriate services and making intra and interagency referrals. The Consumer Liaison is under the general supervision of the Director of Customer Service and Intake.

II. RESPONSIBILITIES / DUTIES:

The Consumer Liaison will be responsible for incoming calls to the Supportive Outreach Team offices and in that capacity will be the first point of contact with current and/or potential program participants.
The Consumer Liaison will:

1. Answer incoming calls to the Supportive Outreach Team office.
2. Gather all pertinent information surrounding individual/family needs.
3. Link individuals/families with any appropriate services offered by the Supportive Outreach Team as well as any other appropriate Community Human Services programs.
4. Provide referrals to individuals/families who are not appropriate for or are seeking services that are unavailable through Community Human Services.
5. Diplomatically handle difficult and demanding calls from potential and/or current program participants and use independent judgment to determine how calls are to be processed.
6. All other duties assigned.

III. QUALIFICATIONS / REQUIRED ABILITIES:

1. A working knowledge of the social service system through life or job related experience.
2. A willingness to work collaboratively in a team setting.
3. Excellent communication and interpersonal skills.
4. Strong organizational, phone and computer skills.
5. Ability to work and travel independently.
6. Must have a valid PA driver's license.

Employee Name: _____

Employee Signature: _____

Date: _____

COMMUNITY HUMAN SERVICES
SUPPORTIVE OUTREACH TEAM
Job Description

PAP CODE: S-4
POSITION NO: 034
EEOC CLASS: 2
WC CLASS: 951

POSITION: Receptionist
REPORTS TO: Director of Customer Service and Intake

I. FUNCTIONAL DEFINITION:

The Receptionist will be the first service connection for walk-in families and individuals coming in to apply for Homeless Assistance Programs and other services offered or for scheduled appointments. The focus of the project is the creation of a service environment that fosters greater autonomy, coordinated care and the ability of participants to bridge the gap from homelessness or near homelessness to safe, affordable permanent housing.

The Receptionist will be responsible for maintaining and promoting hospitality at all times by welcoming, serving and assisting all consumers. The receptionist must always be able to maintain professional boundaries while remaining polite yet firm when dealing with difficult, impatient and/or emotionally distraught customers.

The Receptionist is under the general supervision of the Director of Customer Service and Intake.

II. RESPONSIBILITIES / DUTIES:

The Receptionist will be responsible for greeting all walk-in consumers visiting the Supportive Outreach Team office and in that capacity will be the first point of face-to-face contact with current and/or potential program participants. The Receptionist will also:

1. Check an Excel-based "appointment log" for scheduled appointments, escort visitors to the waiting area and notify the appropriate staff of their arrival.
2. Distributing/ reviewing and assisting consumers with the completion of the application then collecting them to turn over to the Data Administrator.
3. Photocopying, filing and shredding confidential supportive documents as necessary.
4. Monitoring the waiting area and maintaining its resource walls.
5. Provide resources to individuals/ families who are not appropriate for or are seeking services that are unavailable through Community Human Services.
6. Diplomatically handle difficult and demanding potential and/ or current program participants and use independent, good judgment to determine what steps are necessary and what staff, if any, should be contacted.
7. Attend meetings/ trainings to enhance skills and working knowledge to better serve SOT consumers.
8. All other duties as assigned.

III. QUALIFICATIONS / REQUIRED ABILITIES:

1. Excellent communication and interpersonal skills.
2. Strong organizational, phone and computer skills.
3. A working knowledge of the social service system through life or job related experience.
4. A willingness to work collaboratively in a team setting, yet have the ability to work independently.
5. Strong ability to navigate the World Wide Web to familiarize and access various resources.

Employee Name: _____

Employee Signature: _____

Date: _____

Adrienne Walnoha

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OBJECTIVE:

To steward the work of Community Human Services Corporation utilizing holistic approaches in order to provide comprehensive service to individuals, families and communities.

ACADEMIC BACKGROUND AND HONORS:

- Masters of Social Work – University of Pittsburgh (Graduation Dec 1999)
- Commonwealth of PA Licensure for Social Workers #SW-012738-L
- Political Science Masters Program – University of Pittsburgh (1994-1995)
- Bachelor of Arts in Political Science – Chatham College (1994)
  Graduation with Honors – Magna Cum Laude
- Finance and Investing Certificate – American Mgmt & Business Admin Institute
- Phi Beta Kappa (Inducted 1994)
- Chatham Alumnae Award (Received 1994)
- Social Work Alumnae Award (Received 2011)
- National Psychology Honors Organization (Inducted 1993)
- Leadership Development Initiative (Class XIV: 2006-2007)
- Pittsburgh's 40 Under 40: Individuals under 40 Shaping the Region

SPECIAL SKILLS:

- Proficient in Microsoft Office Applications
- Planning and execution of needs assessments
- Conducting focus groups
- Grant writing
- Program development/ assessment: planning, policies, execution and evaluation
- Public speaking

FACULTY EXPERIENCE:

- Adjunct Faculty Member: CCAC (March 2003 - Present), University of Pgh (Jan 2007 – Present)
- Provider Trainings: Act 148, Confidentiality, Professionalism and Boundaries, Documentation and Record Keeping
- Adjunct Faculty and Field Placement Instructor University of Pittsburgh
- Lecturer Chatham College
- Appointee to special committee on academic programming at University of Pittsburgh School of Social Work- Community Organizing and Social Administration and Direct Practice
- Dean of University of Pittsburgh School Social Work Executive Council
- Co Investigator – *Utilization of Principles of Community-Based Participator Research (CBPR) and Concept Mapping to Foster and Inform Community Engaged Research*
- Servant Leadership Experience- Belfast and Dublin for University of Pittsburgh 2011

LECTURES AND PUBLICATIONS:

- *Developing a Tailored Physical Activity Program for People with Severe and Persistent Mental Illness in the Community*. Submitted, August 2013.

- *Creating Synergies: Partnerships for Participatory Evaluating in Human Services (Chapter)*. Community Development in the Steel City: Democracy, Justice, and Power in Pittsburgh. Community Development Journal, September 2012.
- *Translating Community-Based Participatory Research (CBPR) Principles into Practice*. Progress in Community Health Partnerships: Research, Education, and Action; In Press, Fall 2013.
- *Translating Community-Based Participatory Research (CBPR) Principles into Practice: Building a Research Agenda to Reduce Intimate Partner Violence*. Submitted, Fall 2011.
- *Utilization of Principles of Community-Based Participator Research (CBPR) and Concept Mapping to Foster and Inform Community Engaged Research*.
- Community and Campus Partnerships for Health and Wellness Fall 2011 Plenary Session-University of Pittsburgh
- *Using community based participatory research to develop a depression-care model for disadvantaged low-income persons* in Psychiatric Services March 2010
- Photo Voice Workshop (March 2010) at ONTRACK with Recovery Conference
- *Social Workers Respond in Today's Economic Crisis* (March 2010) at PA Southwest Division Social Work Month Forum
- Key Note Address (March 2010) at the SPRING Service Learning Network, Transforming Institutions, Transforming Communities
- *Understanding the Community from the Community*- Co Presenter (May 2010) at ONE: Pittsburgh
- *Creating University-Community Partnerships: Campus Compact* (April 2011) at PA Campus Compact

OCCUPATIONAL HISTORY:

Chief Executive Officer (December 2006 – Present) Community Human Services Corporation, Pittsburgh PA

- Organizational planning and operations
- Supervision of Program Directors and Controller
- Financial management
- Fund development
- Program Development
- Organizational change management
- Community organizing

Interim Executive Director (December 2005 – December 2006) Community Human Services Corporation, Pittsburgh PA

- Temporarily perform all assigned duties upon resignation of the Executive Director including direct supervision of nine additional staff, oversight of the fiscal department and the Lawn Street Center

Director of Homeless Assistance Programs (January 2004-January 2007) Community Human Services Corporation (CHSC), Pittsburgh PA

- Supervision of 15 staff
- Administrative oversight of three homeless assistance programs
- Fund identification and grant writing to support the programs
- Administration of Severe Weather Emergency Shelter
- Administration of Families United Program
- Consolidation and expansion of the following Team Leader responsibilities

Supportive Outreach Team Leader (January 2002-January 2004) CHSC

- Supervise eleven team members
- Monitor and administer HUD, HAP, PATH funded programs
- Pursue new and expanded funding opportunities
- Ensure procedural and fiscal requirements are met for each funding stream
- Develop new and expanded homeless outreach and housing programs

Transitional Housing Program Team Leader (July 2001-Present) CHSC
- Supervise five team members
- Monitor and administer program
- Restructure program to ensure longevity after current funding is exhausted
- Ensure HUD's fiscal and procedural requirements are met
- Develop therapeutic support groups for program participants

Housing Specialist (May 1999-July 2001) Southwestern Pennsylvania AIDS Planning Coalition, Pittsburgh PA
- Conduct countywide HIV/AIDS housing needs assessments
- Arrange focus groups and key informant interviews
- Analyze survey data and draft housing plans
- Provide technical assistance to human service providers for housing projects
- Identify special population housing needs and provide trainings to housing providers to address those needs

Mobile Therapist (December 1999-Present) Youth Advocate Program, Pittsburgh PA
- Therapeutic intervention with youth and families in the home and community
- Conduct clinical assessments
- Draft treatment plans and engage youth and families in goal setting

Therapeutic Staff Support (September 1999-December 1999) Youth Advocate Program
- Provide emotional, social and behavioral support to adolescents
- Facilitate therapeutic support skills in families, educators, and the community

Intern Case Manager (September 1998-May 1999) Pittsburgh AIDS Task Force, Pittsburgh PA
- Research for resource manual dedicated to services for HIV+ individuals
- Daily case management including budgeting, life skills, med management, resource coordination and supportive counseling
- Client Advocacy

Exhibition Staff Manager (March 1998-March 2000) Pittsburgh Filmmakers, Pittsburgh PA
- Supervise four staff members for nightly theater exhibitions
- Perform general book keeping and clerical duties
- Take inventory and place orders

Individual Care Provider (1993-1999) Pittsburgh Area Youths, Pittsburgh PA
- Provide daily developmental, emotional and educational support for youths (age 4-15)

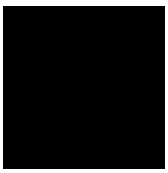
PROFESSIONAL COMMITTEES:

Allegheny Cty Local Housing Option Team
HEARTH Work Group
FEMA Board
WPAPC Housing Services Delivery Committee
Food Security Partnership
Department of Human Services Advisory

Homeless Advisory Board
Conference of Allegheny Providers
Oakland Business Improvement District Board
Affordable Care Act Advisory Team
Neighborhood Partners Program
Oakland Task Force

REFERENCES:

Doug Clewett, Community Human Services
Barb Feige, ACLU
Michael Yonas, Department of Human Services
Al Condeluci, UCP
Tracy Soska, University of Pittsburgh



Natalie M. Ryan
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EDUCATION

University of Pittsburgh Pittsburgh, Pennsylvania

- Earned a Masters Degree in Social Work from the University of Pittsburgh in April 2008
- Received the School of Social Work Community Practice Award for excellence in community organizing at the HI HOPE resource center in Hazelwood
- Obtained the Family Development Credential (FDC) training through Allegheny County Office of Behavioral Health in May 2009
- Earned a Bachelor of Science in Psychology in April 2002
- Obtained a License in Social Work in the state of Pennsylvania, License #SW127996

EMPLOYMENT

2008-2014 Community Human Services
Supportive Service Coordinator, Families United Program

- Coordinate all aspects of the Families United Program, a Housing and Urban Development (HUD) funded permanent housing program that bridges the gap from homelessness to permanent housing
- Independently counsel participants in identifying and working through personal issues
- Link caseload of 25 participants to appropriate referrals for counseling, crisis intervention, and life planning
- Address complaints, incident reports, and challenging behaviors with clients to ensure that their housing is stable
- Encourage participants to maintain a secure living environment so that they may reach their goals and ultimately become independent
- Utilize a strengths based approach to goal planning and assist participants with strategies to reach those goals
- Serve as a Field Instructor to University of Pittsburgh Master of Social Work and Bachelor of Social Work students since 2010.

2008-2010 Allegheny Psychological Services
Mobile Therapist

- Develop mental health interventions appropriate for youth and adolescents in the community
- Provide individual and family therapy with clients in their homes
- Develop care plans based on the needs of individual clients
- Supervise TSS staff assigned to cases
- Participate in interdisciplinary team meetings to ensure collaboration between agencies

2006-2008 Community Human Services

Intern, Supportive Outreach Team and HI HOPE resource center

- Develop and organize a guide for Pittsburgh social service resources to be used throughout Community Human Services Corporation
- Organize donations for the agency and distribute appropriately to clients
- Utilize the Benefit Bank technology to assist clients in accessing benefits

2004-2007 Western Psychiatric Institute and Clinic

Case Manager, Services and Research for the Recovery of the Seriously Mentally Ill

- Provide quality care to a caseload of 30 severely mentally ill individuals
- Earned the Western Psychiatric Institute and Clinic's Making a Difference Award for outstanding case management skills in August, 2006
- Provide advocacy for mental health consumers while teaching independence and self-reliance
- Complete all documentation within specific timeframes as regulated by both state, county, and internal guidelines
- Work independently to meet productivity guidelines for caseload with minimal supervision
- Develop strength-based service plans for consumers that help them identify the areas in their life that need assistance and follow through

LauraEllen Ashcraft, MSW

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Education:

Master of Social Work, *School of Social Work*, University of Pittsburgh, GPA 3.9 December 2013
Concentrations: *community organization and social administration*
Certificate, Human Service Management

Bachelor of Arts, *Social Work,* Millersville University of Pennsylvania, GPA 3.5 May 2012
minor: *Spanish*
Phi Alpha, Theta Alpha Chapter; January 2011-Present

Professional Experience:

Non-profit Consulting; Pittsburgh, PA January 2013 - Present
- Executed the restructuring of homeless services intake process and corresponding evaluations
- Catalyst for development of central intake for multi-program agency including analyzing over 1,500 pieces of data
- Guided strategic planning process for food pantry serving over 1,000 people a month
- Led consumer satisfaction surveys for drop-in center for the past three years' contract renewal process

Social Welfare and the Law, Millersville University of Pennsylvania, Millersville, PA March 25, 2014
Guest Lecturer
- Presented "Legislative Advocacy" to three undergraduate social work classes
- Combined best practices and personal experience in how to talk with elected officials
- Recommended techniques to successfully advocate for human services

DHS Speaker Series, Allegheny County Department of Human Services, Pittsburgh, PA
Presenter September 25, 2013
- Presented "Primary Health Care in Cuba, a Model of System Integration" to forty DHS employees
- Analyzed health care and human service system in Cuba
- Recommended integration techniques for improving service delivery

Bridging the Gaps, Pittsburgh, PA June 2013 - July 2013
Community Health Intern, Gay and Lesbian Community Center:
- Empowered self-expression of 100 LGBTQIA youth through creative qualitative data collection
- Created resource guide for youth, staff, and volunteers of over 75 community services

Allegheny County Department of Human Services; Pittsburgh, PA August 2012 - April 2013
Quality Improvement Intern, Office of Data Analysis, Research and Evaluation
- Co-author of 2012 Allegheny County Child Fatality/Near Fatality Report
- Summarized over 300 pieces of Pennsylvania legislation and analyze effect on DHS
- Performed qualitative case reviews to support state-mandated Child Fatality and Near Fatality Review process
- Analyzed over 200 pieces of child abuse legislation in Pennsylvania and made recommendations to improve policy and practice across child and family- serving systems
- Staffed Permanency Roundtable process funded by Casey Family Programs
- Assisted in local site agency implementation of annual PA DPW Office of Children, Youth and Families Quality Service Review process

Lancaster County Behavioral Health and Disability Services; Lancaster, PA May 2011 - May 2012
Administrative Department Intern
- Collaborated with over forty community leaders, elected officials, and homeless services providers to advance ten year plan to end homelessness
- Coordinated submission process for $30 million grant to US Health and Human Services, Centers for Medicare & Medicaid
- Organized fifty volunteers to conduct US Housing and Urban Development (or federal HUD) Point in Time count of people experiencing homelessness
- Analyzed Pennsylvania Human Service Development Fund Block Grant and projected effect on Lancaster County's $124 million budget

Research:

Honors Thesis, Millersville University of Pennsylvania, Millersville, PA May 2011 - May 2012
Principal Investigator

- Analyzed self-esteem in adults with mental illnesses
- First Social Work major to receive departmental honors
- Successfully competed for Student Research Grant funding

Self-Esteem in an Adult with Mental Illness: A single-subject research design Spring 2011
Millersville University of Pennsylvania, Millersville, PA
Principal Investigator

- Analyzed self-esteem in an adult with a mental illness as affected by a progressive nine module intervention
- Presented Research at 2011 Conference; National Association of Social Workers-Pennsylvania Chapter; October 13-15,2011 & Pennsylvania Association of Undergraduate Social Work Education; April 8-9, 2011

Community Leadership:

National Association of Social Workers 2011- Present
Member, Pennsylvania Chapter

- Legislative Advocacy Day, 2011, 2012, and 2014
- Coordinated participation for Southwest Division in Legislative Advocacy Day 2014
- Coordinated volunteers for 2014 Southwest Division Conference

University of Pittsburgh, School of Social Work, Pittsburgh, PA December 2012 - December 2013
President, Student Executive Committee

- Represent over 400 students in the Master's of Social Work program to School faculty and staff
- Provide oversight to budget of over $14,000 annually
- Review and approve over $3,000 of student conference and travel grants annually

Social Work Organization; Millersville, Pa September 2011-May 2011
President

- Doubled membership participation in bi-weekly meetings and activities
- Increased fundraising and events benefiting local organizations by 200%
- Lead participation of over 100 students in legislative advocacy with NASW-PA in Harrisburg, PA

International Experience:

Center for Race and Social Problems; Havana, Cuba March 8-17, 2013
Student

- Met with more than ten different human service providers
- Researched race, health disparities, and the primary care system in Cuba

Kairos Ministries; Guatemala City, Guatemala July 16-24, 2011 and July 16-24, 2010
Translator

- Provided translation for doctors, nurses, and other non-medical personnel
- Assisted in providing medical services for indigenous populations

Iglesia Menonita de Choele Choel; Rio Negro, Argentina July 2006 and July 2008
Student

- Provided translation services for 20 high school students
- Lived with Argentine family, learned language, and culture

Honors and Awards:

Millersville University of Pennsylvania, Millersville, PA,

Social Work Organization Award	March 2012
Millersville University Junior Leader of the Year	April 10, 2011
Carnegie Community Engagement Classification	March 23, 2011

Decision Support Tools in Human Services Proposal Appendices
Community Human Services

Examples of the following tools/systems:

Job Descriptions:

Resumes:

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Vulnerability Index & Service Prioritization Assistance Tool (VI-SPDAT)

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Concluding Questions (Intake Coordinator Only)

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Additional Notes:

Documentation Regarding Override:

Service Prioritization Decision Assistance Tool (SPDAT v3)

Disclaimer

The management and staff of OrgCode Consulting, Inc. (OrgCode) do not control the way in which the Service Prioritization Decision Assistance Tool (SPDAT) will be used, applied or integrated into related client processes by communities, agency management or frontline workers. OrgCode assumes no legal responsibility or liability for the misuse of the SPDAT, decisions that are made or services that are received in conjunction with the assessment tool.

Contents

Foreword

OrgCode Consulting Inc. is pleased to announce the release of Version 3 of the Service Prioritization Decision Assistance Tool (SPDAT). Since its release in 2010, the SPDAT has been used with over 10,000 unique individuals in over 100 communities across North America and in select locations around the world.

Originally designed as a tool to help prioritize housing services for homeless individuals based upon their acuity, the SPDAT has been successfully adapted to other fields of practice, including: discharge planning from hospitals, work with youth, survivors of domestic violence, health research, planning supports for consumer survivors of psychiatric care systems, and in work supporting people with fetal alcohol spectrum disorders. We are encouraged that so many service providers and communities are expanding the use of this tool, and OrgCode will continue to support the innovative use of the SPDAT to meet local needs.

In preparing SPDAT v3, we have adopted a comprehensive and collaborative approach to changing and improving the SPDAT. Communities that have used the tool for three months or more have provided us with their feedback. OrgCode staff has observed the tool in operation to better understand its implementation in the field. An independent committee composed of service practitioners and academics reviews enhancements to the SPDAT. Furthermore, we continue to test the validity of SPDAT results through the use of control groups. Overall, we consistently see that groups assessed with the SPDAT have better long-term housing and life stability outcomes than those assessed with other tools, or no tools at all.

OrgCode intends to continue working with communities and persons with lived experience to make future versions of the SPDAT even better. We hope all those communities and agencies that choose to use this tool will remain committed to collaborating with us to make those improvements over time.

SPDAT Design

The SPDAT is designed to:

- Help prioritize which clients should receive what type of housing assistance intervention, and assist in determining the intensity of case management services
- Prioritize the sequence of clients receiving those services
- Help prioritize the time and resources of Frontline Workers
- Allow Team Leaders and program supervisors to better match client needs to the strengths of specific Frontline Workers on their team
  Assist Team Leaders and program supervisors to support Frontline Workers and establish service priorities across their team
- Provide assistance with case planning and encourage reflection on the prioritization of different elements within a case plan
- Track the depth of need and service responses to clients over time

The SPDAT is NOT designed to:

- Provide a diagnosis
- Assess current risk or be a predictive index for future risk
- Take the place of other valid and reliable instruments used in clinical research and care

The SPDAT is only used with those clients who meet program eligibility criteria. For example, if there is an eligibility criterion that requires prospective clients to be homeless at time of intake to be eligible for Housing First, then the pre-condition must be met before pursuing the application of the SPDAT. For that reason, SPDAT v3 includes an initial screening tool to assess eligibility.

The SPDAT has been influenced by the experience of practitioners in its use, persons with lived experience that have had the SPDAT implemented with them, as well as a number of other excellent tools such as (but not limited to) the Outcome Star, Health of the Nation Outcome Scale, Denver Acuity Scale and the Camberwell Assessment of Needs.

The SPDAT is not intended to replace clinical expertise or clinical assessment tools. The tool complements existing clinical approaches by incorporating a wide array of components that provide both a global and detailed picture of a client's acuity. Certain components of the SPDAT relate to clinical concerns, and it is expected that intake professionals and clinicians will work together to ensure the accurate assessment of these issues. In fact, many organizations and communities have found the SPDAT to be a useful method for bridging the gap between housing, social services and clinical services. This matter is discussed in further detail at the end of this guide.

Family SPDAT

The Family SPDAT (F-SPDAT) was released in Spring 2012 and is designed specifically for working with families. If your organization would like a copy of that tool you can send your request to F-SPDAT@orgcode.com.

SPDAT Client Disclosure

Clients should be informed that you are using the SPDAT. It is best to explain SPDAT as a tool to help guide them to the right services, as well as assist with the case planning process and track changes over time for those clients that are referred to a case management team as a result of their SPDAT score. At intake or first assessment, it is also prudent to explain to the prospective client that the SPDAT helps to determine the priority with which they will get services and housing. It is important to let the client know that the final determination of a score for any component is a combination of conversation, documentation reviewed, observation and information from other sources. In other words, the outcome is not influenced solely by what they say.

Similar to transparency in case planning, the client should be offered a copy of the Summary Sheet of the SPDAT after it is completed. Whether they may accept or decline, a copy of each SPDAT should be kept in the client's file.

An evaluated best practice from versions one and two of the SPDAT was the use of the SPDAT in the "warm transfer" between intake and the case manager for clients with higher acuity. In the warm transfer, the intake worker, client and case manager (meeting the client for the first time) met together and reviewed each of the 15 components of the SPDAT in detail. Through this process, OrgCode learned:

- clients appreciated understanding the intake worker's assessment and transparency of their reasoning;
- clients appreciated the opportunity to provide commentary on the intake worker's assessment (even though the commentary did not have any further impact on the initial score);
- the receiving case managers appreciated the opportunity to learn more about the clients and ask questions of clarification from the intake worker with the client present;
- the receiving case managers were able to engage in the goal setting process of case planning quicker;
- there was greater continuity between intake and case management. As a result, fewer clients went "missing" between their initial intake and the beginning of the case management services;
- trust between the intake workers and case managers within the community was said to have improved; and,
- clients served through this approach achieved greater housing stability than those

Timing of SPDAT Implementation

It is recommended that the SPDAT begin at intake after the client has been screened for program eligibility. This can be accomplished at a central intake point for the entire community, at various intake points across community agencies and shelters, or upon specific program intake. Although any single organization will benefit from using the SPDAT, the value of the tool and the results it provides are improved as more organizations align in its use across any given service community.

The SPDAT assessment – especially the first assessment done with the client – does not need to be completed in just one client visit. Testing of the tool has demonstrated that there are no discernible differences in assessments conducted over several visits versus those completed in one visit. In the event that a client wishes to take additional time to consider their participation in a program, or in the event that the person conducting an assessment with the individual thinks that it would be advantageous to take a break, they are encouraged to do so. Should the accuracy of the information seem suspect to the person

conducting the interview based upon the client's self-report, keep in mind that the client's consent information can be corroborated from other sources. This type of cross-referencing may be critical for ensuring the best possible assessment that reflects the highest degree of accuracy.

The early application of the tool is a baseline for subsequent SPDAT measurement. The suggested intervals following the baseline SPDAT assessment are as follows:

1. Intake/Early in engagement, i.e., early stages of involvement of Housing Worker and client showing interest in being housed
   In the "warm transfer" between intake and case managers for those clients that are being recommended for supports based upon their SPDAT acuity
3. At or very shortly after (within 2 days of) move in for those clients that are receiving supports

For those clients that are receiving supports, the SPDAT should also be used:

- On or about 30 days
- On or about 90 days
- On or about 180 days
- On or about 270 days
- On or about 365 days

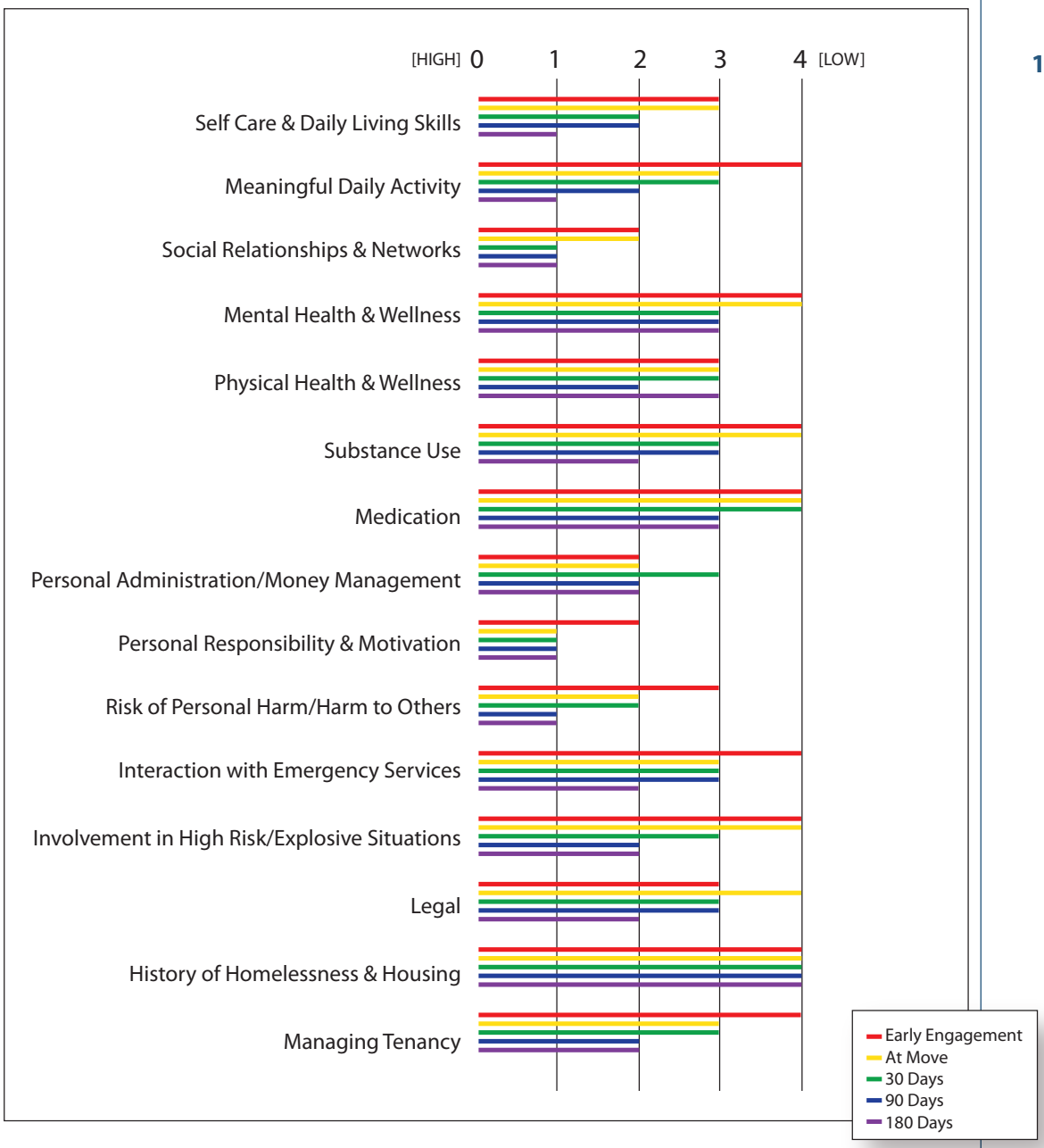
In addition, the SPDAT should be completed any time a client is re-housed or experiences a significant shift in their case plan, either positive or negative. As discussed later, it is not recommended that the SPDAT be completed when a client is in crisis as the episode may misrepresent the overall acuity score. If a client is in crisis, the SPDAT should be completed after the episode has subsided. This may occur in between regularly scheduled applications of the SPDAT.

Graphing Changes

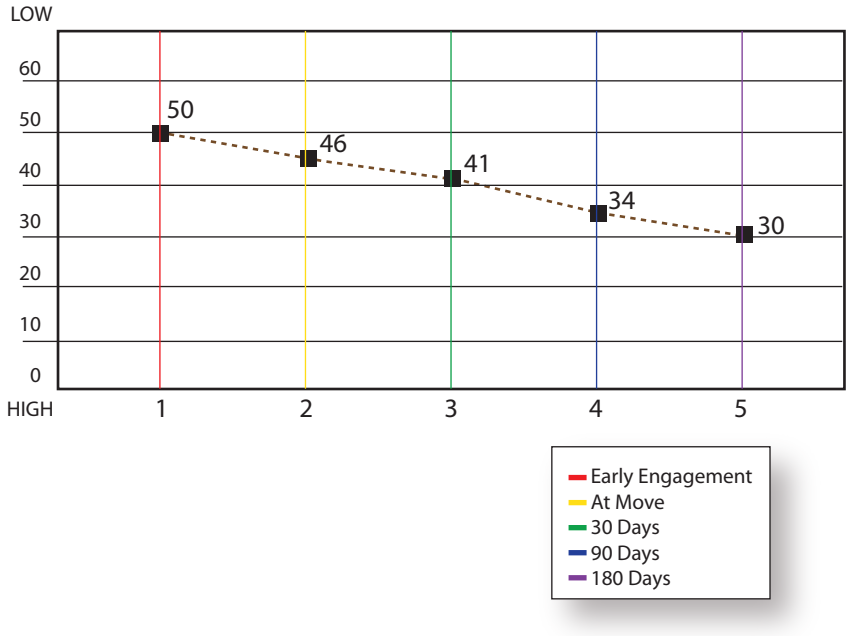
Visuals are an important adult learning strategy. Therefore, it is best practice to visually graph the client's transitions relative to the time intervals noted above. The two examples below illustrate graphing by component or by overall score. The graphs illustrate how the client was assessed during their 5th of 7 applications of the SPDAT—180 days:

Client Assessment

15 SPDAT Components



Client Assessment—Total Component Score



Approaches to Completing the SPDAT

The SPDAT can be completed through observation, conversation, other documentation shared in the intake or case planning process and a client's self-report. Information can also come from the client's case plan, information gleaned from home visits and community accompaniment, or existing knowledge from the client's engagement with your organization. While a conversational approach can be helpful when using the SPDAT, it is not mandatory.

The SPDAT can be completed as part of one conversation in the intake process, or through a series of visits in the early stages of the relationship. For some clients with complex needs, it may be necessary to have several conversations (sometimes in the form of multiple brief conversations) to gather enough accurate information to complete the tool. If you are uncertain of the accuracy of information received from the client, it is encouraged that you repeat the conversation to get clarity.

A guide is included at the end of this document to assist with communication when a conversational approach is used to gain information for completing the SPDAT. The conversation guide comes from practitioners with direct experience in administering the tool.

Using the SPDAT in Providing and Helping to Guide Supports

For those clients who are provided case management or other supports as a result of their SPDAT score, the SPDAT has proven to have great value in helping to guide case planning and support conversations.

Focusing attention on those areas of the SPDAT where the client has higher acuity has been successful in helping clients work through the Stages of Change (Prochaska & DiClemente). It has also proven to be helpful to case managers and other supports in guiding the conversation in client follow up, as well as in establishing objectives for each follow-up visit. Throughout its use, the SPDAT remains a tool that is client-centered and allows for strength-based approaches to service delivery.

Noting Discrepancies

With many clients you will gather information or observe behavior that may be contradictory to their self-assessment. This can be a positive aspect of case management process when working towards change. Do not shy away from being transparent in your assessment, noting the discrepancies whenever they appear.

Components of the SPDAT

The SPDAT is divided into 15 components (A to O below). Each component has a description that categorizes the scoring relative to each component.

The scoring begins with "0" that indicates higher functioning/non-issue. Level "4" indicates a more serious issue/situation. While a description is provided for each component complete with definitions, it is useful to include specific client examples in conjunction with each score. Certain scenarios require careful consideration about which score to use when the scenario does not precisely match the descriptions. In these instances, it is important for staff to provide their rationale for the score indicated.

For each component, there is an opportunity to record what you observed or the comments that the client disclosed that resulted in the score.

COMPONENT A

Self-Care and Daily Living Skills

A. Self Care and Daily Living Skills

This component is concerned with the functions of taking care of oneself, meeting daily needs independently, and living autonomously. Behaviours of interest here include such things as taking care of one's own personal hygiene, as well as being able to cook, clean, and do laundry.

This component also gives consideration to those individuals who are collectors or hoarders. Crucial to this assessment is the degree to which they are aware that such behaviours are an issue that is negatively impacting their life.

Under the scoring scheme below, "lives independently" refers to the ability to live without permanent on-site supports. It does not include individuals living in couples or with roommates.

If the individual is homeless at the time of assessment the most that they can receive is a 2.

0 =	Takes care of self and meets all daily living needs independently & lives independently.
1 =	Takes care of self and meets all daily living needs by infrequently accessing other community resources as needed.
2 =	Attempts to take care of self and meet all daily living needs, but has a few areas where assistance is sometimes required; may not be living independently (staying in a shelter).
3 =	Not always taking care of self and/or not always aware of what needs to be done to take care of self or daily needs; can require prompts; requires frequent assistance; may excessively acquire belongings (hoard or collect) but is aware that it is an issue.
4 =	Not taking care of self or meeting daily needs; often unaware and almost always needs prompts; requires intensive, frequent assistance; may excessively acquire belongings (hoard or collect) but is not fully aware or is not at all aware that it is an issue.

COMPONENT B

Social Relationships & Networks

B. Social Relationships and Networks

This component is concerned with social relationships and networks. Covered in this component is the client's engagement with friends and family, and to some degree their interaction and relationships with professionals.

There is no quantifiable measure of how many friends or family members a client should have, or the level of interaction that determines a relationship. More than one relationship involving fairly frequent interaction over several months is encouraged.

In some instances, the capacity of an individual to trust or make an informed decision

about social interaction can be a cause for concern. This is especially true of those clients who have a history of victimization, engagement in dependent relationships, and who are exploited for goods or services.

It is possible for a client to be satisfied with a relationship that is in fact detrimental to their own wellness. These types of situations are captured as a 4 on the scoring scale.

0 =	Has friends and/or family supports as they would like them, and has maintained those relationships for greater than 6 months.
1 =	Has some friends and/or family supports, and/or working on relationships, and/or the relationship is how they would like, but for less than 6 months.
2 =	Engaged in relationships with friends and/or family, occasionally with some difficulties and/or still at the very early stages of relationship development.
3 =	Discussing or is in the early stages of establishing relationships with friends and/or family, but having difficulty maintaining contact or advancing the relationship; or client has relationship with friends or family but it is have some negative consequences on the client's wellness. May be talking to new people, but not at a stage of trusting or liking them yet. Meanwhile, the individual may maintain good relationships with professionals.
4 =	While may have acquaintances or relationships with people out of convenience or necessity – including co-dependent relationships or feelings of need for the relationship based upon past victimization or abuse, no meaningful social relationships and networks with people of their choosing that they like; or client has relationship with friends or family but it is having serious consequences on the client's wellness. While the individual may have relationships with professionals, they are not consistently good.

C. Meaningful Daily Activity

COMPONENT C
Meaningful Daily Activity

This component is concerned with the ways in which clients spend their days. The activities that a client engages in are informed by their own choices. These activities should extend beyond those pursuits that are informed solely by the requirements of the case plan. Meaningful daily activities should provide engagement for most, if not all, days of the week.

Examples of activities that are not considered to be meaningful daily activities include using substances for large portions of the day and/or spending large portions of the day finding/getting money to pay for substances and/or sleeping or being otherwise incapacitated as a result of their substance use and/or acquiring substances; survival activities (e.g., binning; bottle collecting; sex work); therapy; doctor's appointments and medical treat-

One's choice of meaningful daily activity is informed by personal and cultural preferences, as well as financial capacities. Of importance is not only that the client is engaged in

meaningful daily activities, but that they also have a sense of fulfillment on some level from the participation in that activity. This usually is equated with intellectual, emotional, social, physical or spiritual fulfillment.

In addition, the activities and the sense of fulfillment should provide a sense of personal satisfaction. There is no specific metric for this satisfaction other than a personal feeling of self-esteem, contentment, confidence, recovery, etc.

While it is reasonable for an individual to enjoy solitary meaningful daily activities, there is an expectation that some activities will involve interacting with the community outside of their immediate housing situation.

0 =	Has activities related to employment, volunteering, socio-recreation, etc. that provide fulfillment intellectually, socially, physically, emotionally, spiritually, etc., occupying most times of day and most days of the week, and which provide a high degree of personal satisfaction.
1 =	Has some activities related to employment, volunteering, socio-recreation, etc. that provide some fulfillment intellectually, socially, physically, emotionally, spiritually, etc., occupying some times of the day and/or some days of the week, which provide a good degree of personal satisfaction.
2 =	Attempting activities that may provide fulfillment intellectually, socially, physically, emotionally, spiritually, etc. but not occupying most days or most parts of any given day, and not yet providing a good degree of personal satisfaction.
3 =	Discussing or in early stages of attempting activities that may provide fulfillment intellectually, socially, physically, emotionally, spiritually, etc. but not fully committed. At times disengaged from activities, and activities are not yet occupying most days, nor providing personal satisfaction.
4 =	Not engaged in any meaningful daily activities that provide fulfillment intellectually, socially, physically, emotionally, spiritually, etc. Very little to no personal satisfaction.

COMPONENT D

Personal Administration & Money Management

D. Personal Administration and Money Management

This component is concerned with a client's ability to manage their money and the associated administrative tasks such as paying bills, filling out forms, completing a budget, and submitting necessary paperwork or documentation.

Income sources should be considered formal (for example, employment income; income support through welfare, etc.) as well as informal (for example, proceeds from sex work; "working under the table"; drug sales, etc.).

that they manage that small amount of income quite well, but still run out of money towards the end of the month in most, if not all, months. This shortfall of funds is not an issue with their ability. It is an issue with the amount of money they receive relative to their other expenses such as housing. These individuals are classified as a 2.

0 =	Has an income source and manages all personal finances and benefits independently. Can pay bills and fill out all appropriate paperwork and forms without assistance from others. Has been doing so for 6 months or more.
1 =	Has an income source and manages all personal finances and benefits independently, and can pay bills, and fill out all appropriate paperwork and forms without assistance from others. Has been doing so for less than 6 months.
2 =	Has an income source and manages most personal finances and benefits with a little help from time to time, which may include help paying bills, filling out paperwork and forms or using a voluntary trusteeship program. Also includes those individuals that manage their money well with what they receive but require assistance from the likes of a food bank at the end of the month to make ends meet, as well as those that are on and off income support more than 2 times in any 12 month period.
3 =	Has an income source, but requires frequent assistance to manage personal finance and benefits, which may include the use of a guardian or trustee (which may be voluntary). Likely requires intensive supports to take care of paperwork and forms. Likely requires prompts, reminders and/or assistance paying bills and may not always budget appropriately for all bills. Likely requires intensive assistance budgeting. If a substance user, is likely not involved in accounting for substance use in budgeting. May have significant debt load, including "street debts" and/or gambling debts.
4 =	May or may not have an income. Requires intensive assistance with personal finances and benefits, which may include the use of a guardian or trustee (which may be voluntary). Almost always fails to appropriately fill out forms or complete paperwork. Cannot create or follow a monthly budget. Almost always needs prompts, reminders and/or assistance paying bills and almost always does not have enough income to cover all bills from the previous month (and may not comprehend this, thinking bills are consistently higher than they should be). Most likely not budgeting for substance use, if a substance user. Likely to have significant debt, including "street debts" and/or gambling debts.

COMPONENT E
Managing Tenancy

E. Managing Tenancy

This component is concerned with an individual's management of their apartment. The primary foci are payment of rent, not disrupting the enjoyment of other tenants, positive relations with the landlord/superintendent and avoiding unit damage.

Any person who is homeless at the time the SPDAT is completed shall be considered a 4.

This component is specifically concerned with the retention and implementation of skills necessary to care for one's apartment and manage their tenancy.

Third party payment of rent is not considered to be assistance in the payment of rent. That is an administrative function of how rent gets paid (not unlike a direct transfer for a mortgage payment), and not necessarily an indication of need for assistance.

0 =	Has taken care of apartment unit for 6 months or more without any external support including such things as payment of rent, following lease agreement and physically maintaining unit in good shape.
1 =	Has taken care of apartment unit for less than 6 months without any external support including such things as payment of rent, following lease agreement and physically maintaining unit in good shape.
2 =	Needs assistance in taking care of the apartment unit up to three times in any three month period or a maximum of once per month, which may include assistance paying rent, managing situations that the landlord has taken exception to, or in physically maintaining the unit in good shape. Has not needed to be re-housed within the past three months.
3 =	Needs assistance in taking care of the unit four to nine times in any three month period or two or more times per month, which may include assistance paying rent, conflict resolution and problem solving and mediation with the landlord, or in physically maintaining the unit in good shape. Has been re-housed as a result of these or similar issues within the past three months or will likely need to be re-housed within the next two months.
4 =	Needs assistance taking care of the unit ten or more times in any three month period or three or more times in any given month, which may include assistance paying rent, conflict resolution and problem solving and mediation with the landlord, or in physically maintaining the unit in good shape. Will need to be re-housed imminently or the re-housing process may be underway. This category also includes all clients that are not yet housed at time of baseline evaluation.

F. Physical Health and Wellness

This component covers physical health and wellness.

There are four considerations related to the client in this component: whether they have a physical health issue; the severity of the health issue; whether they are accessing care for that physical health issue (including those who may wish to access care but are unable to based upon insufficient health resources in the community); and, how the individual views wellness.

In this component, minor physical health issues are those that can be treated without overly intensive care or through non-obtrusive, accessible interventions. For example, an individual who breaks their arm and requires a cast, but does not require surgery or extensive physiotherapy may be considered to have a minor physical health issue. Another example might include an individual with an arthritic knee who routinely uses a mobility-assistance device.

Chronic health issues include, but are not limited to, conditions such as heart disease, cancer, diabetes, and immunological disorders.

Intensive health supports includes the provision of professional wound care, assistance with a colostomy bag, injection medications and similar interventions.

	No physical health issues. Completely well.
1 =	Physical health issues are relatively minor, or in the event of a chronic condition, the individual has considerable knowledge of their health needs and closely follows the treatment protocol. The individual is connected to appropriate professional resources.
2 =	Physical health issues present and while the individual is following treatment protocols, day to day functioning is still impacted.
3 =	Physical health issues present, which may be chronic in nature and/or requires intensive health supports, but the individual is not connected to appropriate professional resources either by choice or because of insufficient community resources. In some limited situations an individual may be connected to supports and following treatment protocols, but the treatment is having very little to no impact on improving day to day living and/or the individual cannot follow all parts of the treatment protocol (e.g., required to rest, but no place to rest 24/7 because of being homeless). The individual may not see the total value of wellness and getting better.
4 =	Serious health issues which are most frequently co-occurring, chronic and complex. In most instances the individual is not connected to appropriate professional resources, or the individual is involved in treatment that is having no impact on the condition and/or the individual cannot implement the treatment protocol; and/or, the individual is palliative.

COMPONENT G

Mental Health & Wellness & Cognitive Functioning

G. Mental Health and Wellness & Cognitive Functioning

This component covers mental health and wellness, as well as cognitive functioning. The intent is not to provide a diagnosis. While there may be many reasons for an individual to have a compromised ability to communicate clearly or engage in socially appropriate behaviour, these may be clues, along with the likes of delusions, hallucinations, incomprehensible dialogue, or apparent disconnect from reality. A suspected or untrained observation of mental illness or compromised cognitive functioning can be a prompt for further dialogue to have an appropriate professional engage.

There are a range of mental health conditions. Consideration should be given to any individual who would fall under Axis I, II or III disorders according to the DSM-IV (Diagnostic and Statistical Manual).

An Axis I disorder covers clinical disorders including major mental disorders and learning disorders. An Axis II disorder covers retardation of mental capacity and personality disorders. An Axis III disorder covers acute medical conditions or physical disabilities such as brain injuries that aggravate existing symptoms or can present symptoms similar to other disorders.

Caution should be exercised in considering whether an individual qualities as having a serious and persistent mental illness. Some considerations in making this determination would include such things as: whether they have been hospitalized for psychiatric care two or more times in the last two years; whether they have an Axis I or Axis II disorder; and, whether it is reasonable to believe they would likely be hospitalized for psychiatric care according to a mental health professional.

Included in consideration of compromised cognitive functioning are barriers to daily functioning that result from the likes of head injuries, learning disabilities (as validated by neuropsychological or psycho-educational testing), and/or developmental disorders. In most instances barriers to daily functioning as a result of compromised cognitive functioning will include one or more of the following: diminished aptitude; issues with memory especially related to visual or verbal acquisition, retrieval, retention and/or recognition; attention issues such as decreased visual or auditory spans of attention; compromised executive functioning such as the ability to plan, prioritize, organize or sequence activities.

0 =	No mental health or cognitive functioning issues disclosed, suspected or observed.
1 =	The individual has disclosed that they have a mental health issue or diminished cognitive functioning, and are effectively engaged with professional assistance to manage the issue; or an individual is in a heightened state of recovery, fully aware of their symptoms and wellness and manages their mental health and wellness independently.
2 =	The individual has a disclosed, suspected or possibility of mental health issues and/or cognitive functioning issues based upon that which is observed or heard, but any impact on communication, daily living, social relationships, etc is minimal. Possibly without formal diagnosis. If diagnosed, may not require anything more than infrequent assistance.
3 =	The individual has a significant mental health issue disclosed, suspected or observed, or the individual has significantly diminished cognitive functions, most likely having an impact on communication, daily living, social relationships, etc. The individual may have supports but the mental health and/or cognitive functioning issues still have considerable impact on day-to-day living. Assistance is required, but the client has no consistent, ongoing assistance.
4 =	The individual has a serious and persistent mental health issue disclosed, suspected or observed and/or the individual has major barriers to daily functioning as a result of compromised cognitive functioning; most likely greatly impacting communication, daily living, social relationships, etc., While most often without ongoing assistance, it is possible that the individual does have supports, but their serious and persistent mental health issues or major cognitive functioning issues are still greatly impacting day to day living.

COMPONENT H

Medication

H. Medication

This component addresses medications that have been prescribed by a professional and that are being used in an amount and for a purpose that is consistent with the prescription.

Over the counter medications are not included here. If a client is using an over the counter medication for a purpose other than intended, it may be considered as part of the component on substance use.

Those who take medications that are not prescribed by a medical professional, even if it is for a mental health or physical ailment, should be considered substance use.

0 =	Does not take any medications, or has demonstrated consistent self-management of medications for greater than 6 months.
1 =	Takes medications and has been self-managing the use of medications for less than 6 months.
2 =	Takes medications but requires some assistance from time to time, including prompts to take the medication, understanding what the medication is for and/or instruction on proper storage or use of the medication.
3 =	The individual takes medications, but may forget to take them regularly or may use them improperly from time to time. If the individual is selling their prescription drugs to others, they keep the majority of the prescription for themselves. Likely requires significant assistance to manage, including regular reminders, schedules or prompts, understanding what the medication is for and/or instruction on proper storage or use of the medication. May also include individuals who have had their prescription changed within the past month and the effects and routine of the new regime are not yet fully worked out, but are not having a debilitating impact on the person's health or daily activities.
4 =	The individual does not use medications as prescribed, which may include frequently failing to take the medication. This includes individuals with a prescription that is never filled (including those who did not fill the prescription because of financial restraints). If the individual is selling their prescription drugs, most or all of the prescription is sold. The individual may also demonstrate a lack of interest or understanding in how and when to take the medication, what it is for, or how it should be stored or used. May also include individuals who have had their prescription changed within the past month and the effects and routine of the new medication are significantly impacting day-to-day living, their health or daily activities.

I. Interaction with Emergency Services

COMPONENT I

Interaction with Emergency Services

This component is concerned with interactions with emergency services.

An interaction is not a casual encounter such as striking up a conversation with a police officer on the street, passing by a firefighter battling a blaze, seeing ambulance workers provide care on the street, or taking a friend to the emergency room. The interactions this component is interested in are deliberate and direct interactions between the client and staff from emergency rooms in hospitals, police officers, ambulance attendants and/or fire-fighters (including in the capacity of providing First Aid/CPR – not solely in their function of fighting fire).

Also relevant to this component is the client's interaction with crisis services, and their time spent in hospitals for overnight or long term care.

0 =	No interaction with emergency rooms, hospital, crisis service, police, ambulance or fire for more than 6 months.
1 =	No interaction with emergency rooms, hospital, crisis service, police, ambulance or fire for less than 6 months.
2 =	One to three interactions with emergency rooms, hospital, crisis service, police, ambulance and/or fire in the last 6 months.
3 =	Four to nine interactions with emergency rooms, hospital, crisis service, police, ambulance and/or fire in the last 6 months.
4 =	Ten or more interactions with emergency rooms, hospital, crisis service, police, ambulance and/or fire in the last 6 months.

J. Involvement in High Risk and/or Exploitive Situations

COMPONENT J

and/or Exploitive Situations

This component is concerned with a client's involvement in high risk and/or exploitive situations.

Involvement on the part of the client may have been voluntary or involuntary. It is both what they have done as well as what has been done unto them.

While not an exhaustive list, examples of high risk and exploitive situations include: sex work; injection substance use; slavery; drug mule; unprotected sexual engagement (outside of a monogamous relationship); binge drinking; sleeping outside as a result of blacking out; being directly or indirectly forced to work; being used for any activity against one's will, consent or knowledge; being short-changed for work undertaken; being in environments prone to violence; engaging in activity solely for the benefit of others without any personal gain or benefit.

This component also includes those individuals leaving an abusive situation given the high risk the abuser presents. As the mental or physical abuse experienced by the victims is a daily occurrence, these victims are considered a 4.

People who have been sleeping rough may also be considered to be in a high-risk situation. Without protective clothing and appropriate sleeping gear they run the risk of exposure and temperature related ailments. Depending on where they are sleeping rough, they may be exposed to higher incidents of violence, sexual assault, and theft.

0 =	Has not been involved in a high risk or exploitive situation for more than 6 months.
1 =	Has not been involved in a high risk or exploitive situation for less than 6 months.
2 =	Has been involved in one to three high risk or exploitive situations in the last 6 months.
3 =	Has been involved in four to nine high risk or exploitive situations in the last 6 months.
4 =	Has been involved in ten or more high risk or exploitive situations in the last 6 months.

COMPONENT K

Substance Use

K. Substance Use

This component covers substance use, which is the use of alcohol (including non-palatable alcohol) and/or other drugs.

Prescription drugs, including methadone treatment, are not considered in this component unless they are used for a purpose other than for how they were prescribed. Otherwise, they are considered in the component on medication.

Information on usage thresholds has been drawn from leading addiction scholars and researchers. It is acknowledged that there can be differences in opinion amongst learned professionals in this field concerning the distinction between substance use and abuse, and in the amounts that can be safely consumed on a daily or weekly basis. "Acceptable consumption thresholds" for alcohol are: 2 drinks per day or 14 total drinks in any one week period for men; 2 drinks per day or 9 total drinks in any one week period for women.

Non-palatable alcohol includes any substance with an alcohol content that is not intended for sipping or regular consumption. This would include substances such as Listerine, cooking wine and alcohol based hand-sanitizers.

Binge drinking is classified as any instance where a male consumes 5 or more drinks or a female consumes 4 or more drinks in a single hour; or when 10 or more drinks are consumed in a single drinking episode (for example, an evening of drinking).

0 =	Has not used drugs or alcohol for 12 months or more.
1 =	Does not use drugs. Alcohol consumption does not exceed acceptable consumption thresholds. Substance use has no impact on daily functioning. If practicing abstinence, has achieved at least 14 days of sobriety.
2 =	Up to four incidents of using drugs and/or alcohol in a one month period, that may occasionally include non-palatable alcohol, and/or may occasionally include binge drinking. Any impact that the substance use has on daily functioning is infrequent. If there are health impacts as a result of substance use, the impacts are relatively minor.
3 =	More than four incidents of using drugs and/or alcohol in a one month period, that may include non-palatable alcohol, may include binge drinking, and is likely to exceed daily maximum acceptable consumption thresholds on a regular basis. Impacts of the substance use on daily functioning are frequent, even if the individual does not acknowledge these consequences. Health is likely compromised as a result of alcohol or drugs.
4 =	Use of drugs and/or alcohol is likely daily, frequently including non-palatable alcohol, most often including binge drinking, most often using to the point of complete inebriation (may include passing out). Impacts of the substance use on daily functioning are severe and may be life threatening.

COMPONENT L

Abuse and/or Trauma

L. Abuse and/or Trauma

This component is concerned with the impact of abuse or trauma experienced by the individual, including inter-generational impacts. Included in this component are individuals who are survivors of abuse or trauma as children. Additionally, traumatic events may be very recent or ongoing, and may be the cause of the current period of homelessness. Note that the experience is not automatically considered to be a traumatic event for all people.

For the purpose of this component institutional abuse is considered a history of abuse or trauma.

This component uses self-reports to assess the impact of abusive and traumatic experiences on day-to-day life, and to assess the state of recovery, if any. The purpose of this component is not to uncover what the traumatic events were/are, and care must be exercised to avoid exploring the traumatization through questioning.

In recognition that not all have access to professional counseling services, therapeutic recovery should considered broadly. This is particularly pertinent when considering culturally significant healing practices.

0 =	The individual does not report a past or present experience of abuse and/or trauma.
1 =	The individual has a history of abuse and/or traumatic events, but reports no serious consequences on present functioning and/or ability, or indicates resolution of past abuse through therapeutic means.
2 =	The individual has a history of abuse and/or traumatic events that are impacting present functioning and/or ability. The individual may currently be engaged in therapeutic attempts at recovery, but does not consider self to be recovered.
3 =	The individual has a history of abuse and/or traumatic events that are severely impacting present functioning and/or ability. The individual has not attempted therapeutic recovery.
4 =	The individual is currently experiencing abuse or a traumatic event that is causing the current period of homelessness. No attempt at therapeutic recovery has been made.

COMPONENT M

Risk of Personal Harm/ Hatrm to Others

M. Risk of Personal Harm/Harm to Others

This component is concerned with risk of personal harm and/or risk to others.

Included in this component are both actions and written or verbal statements. That is, the undertaking of harm as well as the threatening of harm.

There are no guaranteed ways in which someone can predict if another person will act in ways harmful to themselves or others.

The assessment for this component takes into consideration the likelihood of risk which considers a number of indicators, the history of harming oneself or others, the time since the last action or threats, and, the individuals ability to de-escalate.

The indicators that help inform the likelihood or risk include such things as:

- Severe depression
- Giving away personal possessions
- Expressing plans for a suicide attempt
- Sense of hopelessness
- Access to lethal means such as a weapon or toxic substance
- Previous suicide attempts
- Excessive substance use
- Social withdrawal and isolation
- History of incarceration for violent acts
- Specific threats of violence against specific people
- Strong feelings of being wronged by a specific person or group of people
- Expressing plans for a violent act against another person or group of people

0 =	No perceived risk to self or others. No known history of harming self or others. No known threats or making of harmful statements.
1 =	Limited risk to self or others. No history of harming self or others within the past 12 months, though may have limited exposure from the past. No threats or making of harmful statements within the past 6 months.
2 =	Possible risk to self or others. No history of harming self or others within past 12 months, though may have exposure from the past. May have very infrequently made statements concerning potential harm to self or others within the past 6 months, but no action taken. Individual de-escalated after making statements.
3 =	Probable risk to self or others. Episode of attempting or actually harming self or others within past 12 months and likely verbal or written statements threatening harm to self or others within the past 6 months.
4 =	Imminent risk to self or others. Clear, strong threats of harming self or others, without de-escalation. Recent frequent episodes of attempting or actually harming self or others.

N. Legal

COMPONENT N

Legal

This component is concerned with legal issues.

Legal issues pertain to any offences by any order of government or any area of law enforcement to which the person is subject to such things as paying a fine, undertaking community service, or being incarcerated.

Unless it is a single individual involved in such matters, it does not include any involvement in family court or child custody apprehension, as these are dealt with in a separate component.

The time frames references below pertain to the length of time since the most recent court appearance (not the time since the charge which may have occurred quite a bit of time before).

0 =	No legal issues for 12 months or more.
1 =	At least one legal issue in the past 12 months, but it was discharged or resolved without community service, payment of fine or incarceration. No current legal issues.
2 =	At least one legal issue in the past 12 months and it was resolved through payment of fine or community service. It may also include current legal issues that are unlikely to result in loss of housing or incarceration.
3 =	At least one legal issue in the past 12 months that may result in fines that may put housing at risk and/or periods of incarceration of three months or less that may place housing at risk.
4 =	At least one legal issue in the past 12 months that resulted in fines that place housing at imminent risk and/or periods of incarceration greater than three months.

COMPONENT O

History of Homelessness & Housing

O. History of Homelessness and Housing

This component is concerned with the client's history of homelessness and housing.

The cumulative duration of homelessness is concerned with the total number of days that a person was homeless within the specified time period. It acknowledges that a person may have been homeless for one or two days, housed, then homeless again. The number of days spent homeless is added up to produce the cumulative total.

The types of homelessness captured in this section include absolute homelessness (sleeping rough; staying in shelters; living in a car; squatting) as well as relative homelessness (couch surfing; overcrowding). What is most important is the client's own determination of what constituted their homelessness. Prompts may be necessary to assist clients in making a determination of when they considered themselves to be housed or homeless.

This component will not change in later assessments of the SPDAT unless the client reveals new information.

0 =	years, which may include being recently re-housed.
1 =	Cumulative duration of homelessness was between 8 and 30 days over the past four years, which may include being recently re-housed.
2 =	Cumulative duration of homelessness was between 30 days and 2 years over the past four years.
3 =	Cumulative duration of homelessness was between 2 years and 5 years over the past decade.
4 =	Cumulative duration of homelessness was greater than 5 years over the past decade.

Summarizing Scores

It is recommended that Frontline Workers, Team Leaders and Program Supervisors build familiarity with the descriptions of all of the components above. The objective is to achieve competence in applying the SPDAT without having to reference the complete SPDAT Manual. The most important tool is the Summary Sheet on the next page. The Summary Sheet should be the only documentation visible to the client when using a conversational approach to gaining input for the SPDAT. As previously noted in the section about disclosure, the client should be offered a copy of the Summary Sheet after the application of each SPDAT.

In the event of uncertainty between two possible scores for a component, i.e., if you are uncertain if the client is a "2" or a "3", the higher score should be used.

The Comments section should be used throughout the Summary Sheet for five fundamental reasons:

1. The Comments section should reveal the source of the information that led to the assessment: Self-Report, Observation, Case Notes, Conversation, Other Documentation.
2. The Comments section should be used to note if there was uncertainty and a higher score for the component was used—as noted above.
3. The Comments section can be used to note if any particular circumstances seem to be impacting the assessment score for an individual component.
4. The Comments section can be used to make note of any relevant trends in the component for the client.
5. The Comments section can be used to make any notes that will be helpful for subsequent SPDAT evaluations.

Practitioners should write comments factually. Comments should only be relevant to the context of the SPDAT and mindful of the fact that clients will be offered a copy of the SPDAT Summary Sheet.

When summarizing the scores, it is important that a score is noted for every component. For example, noting a "0" is appropriate, leaving the component blank with an implied "0" is not appropriate. After there is a value for each component, a total score can be tallied for the client. This final score represents the client's level of acuity out of a total possible rating of 60.

SPDAT SUMMARY

Client: _____

Worker: _____

Date: _____

Component	Assessment (0, 1, 2, 3 or 4)	Comments
A. Self Care and Daily Living Skills		
B. Social Relationships and Networks		
C. Meaningful Daily Activity		
D. Personal Administration and Money Management		
E. Managing Tenancy		
F. Physical Health and Wellness		
G. Mental Health and Wellness		

Component	Assessment (0, 1, 2, 3 or 4)	Comments
I. Interaction with Emergency Services		
J. Involvement in High Risk and/or Exploitive Situations		
K. Substance Use		
L. Abuse and/or Trauma		
M. Risk of Personal Harm/ Harm to Others		
N. Legal		
O. History of Homelessness and Housing		
TOTAL		

Prioritizing Service Based Upon Score & Guiding Supports

The recommended intervention and approach to supports is linked to the level of acuity.

Scoring Range	Intervention	Comments
	Housing Help Supports	Generally high functioning individuals with shorter periods of homelessness. Needs are not as complex in most of the SPDAT categories. Are most likely to solve their own homelessness, perhaps with very brief financial assistance, shallow subsidy, access to apartment listings and the like.
20-39	Rapid Re-housing	With some supports, though not as intensive as Housing First, the individuals can access and maintain housing. The focus of the supports will more likely be on a smaller number of SPDAT components. Support services do not last as long as Housing First supports.
40-60	Housing First	These are individuals with more complex needs who are likely to benefit from case management supports either through Intensive Case Management or Assertive Community Treatment. Scores in the SPDAT are likely to be higher (3s and 4s) in many of the components.

Within each category, those clients scoring closer to the top of the threshold are the first priority. For example, if two clients have undergone an intake and one scores a 53 and the other a 49, and there is only one opening on a caseload, the individual with the highest score is served first.

For those clients who receive a Rapid Re-housing or Housing First service, it is expected that the overall SPDAT score is likely to decline over time during the period when a client is receiving supports even though there may be fluctuations in any of the 15 elements from one review to the next.

Consistently lower scores (which reflects overall life improvements and increased stability) can be used to focus on "graduation" from program supports, leading to decreased and then terminated service supports.

If a client is in crisis at the time of an SPDAT measurement, it may misrepresent overall acuity. To provide greater accuracy in the overall measurement, it is recommended that an additional SPDAT evaluation be taken once the crisis is resolved.

Regardless of the scoring and priority sequencing system outlined above, circumstances may that require additional information be considered in establishing the priority of clients to be served. This decision rests with the Team Leader and/or Senior Managers/Central Administrators within the community. It is incumbent upon these decision makers to justify exceptions in service delivery, acknowledging that there can be many reasons for an exception based upon local circumstances at any point in time. Known as the "notwithstanding" clause of SPDAT use, it is important that this approach is used infrequently, in limited circumstances and with sufficient justification.

System Navigation and Support for Clients Can Be Informed Using SPDAT Results

Individual communities as well as cross-agency partnerships can create specific processes to better assist clients relative to their SPDAT score.

For example, a SPDAT score of 52+ that includes higher scores related to mental health and wellness and/or physical health and/or substance use may trigger a referral or secondary assessment by a specialized health, mental health or addiction resource such as an ACT Team or another specialized service team.

Within individual teams, Team Leaders can use the SPDAT scores in each component to help inform which Follow-up Support Worker may have a skill set or expertise to best assist with a specific circumstance. The assigning of a Follow-up Support Worker to a particular client can be rationalized using SPDAT information.

There may also be instances where SPDAT scores are employed to enhance inter-agency partnership or overall caseload balance throughout the service system. For example, Team Leader and/or Senior Management meetings across agencies may result in client transfers among Housing First teams to ensure more balance across teams of clients with higher SPDAT scores.

Local Variations in SPDAT Use

Locally, system administrators can develop their own rules pertaining to priorities from scoring, system navigation, integration with a Homeless Management Information System and the use of the notwithstanding clause.

Individual organizations and communities may not adjust the scoring, ranking or descriptions of any of the 15 components.

Guide to Assist SPDAT Conversation

As noted previously, much of the information for completing the SPDAT can be attained through methods other than a specific conversation about the components. For example, a home visit with a client may self-reveal that they are not managing their medications. This information is used for the SPDAT rather than seeking the information again—unless there

was confusion about the client's intent. Another example might be a client who shares some legal documentation that provides information relative to understanding how to complete the Legal category of the SPDAT. Information may also be obtained for the SPDAT through observation. Home visits are opportunities to assess the components Self Care and Daily Living Skills and/or Managing Tenancy.

The SPDAT is also integrated with information from the support and case planning process. Conversations with clients relative to their goals and activities often provide sufficient information for the assessment of many of the other components. Information obtained through the support and case planning process does not need to be repeated during the SPDAT assessment unless clarification is required.

When a specific conversation about the SPDAT is needed, the following questions can be helpful in guiding and assisting with that conversation. These questions have worked well during implementation of versions one and two of the SPDAT. To improve implementation, we encourage organizations within each community to share the questions that they are using to gain information from clients.

The following table outlines questions that will guide and assist the conversation. These questions are suggestions, and are not mandatory to achieve responses for the SPDAT. The questions are organized by SPDAT components:

Component	Probing Question(s):
A. Self Care and Daily Living Skills	• Do you have any worries about taking care of yourself? • Do you have any concerns about looking after cooking, cleaning, laundry or anything like that? • Do you ever need reminders to do things like shower or clean up? • If I were to come over to your last apartment, what would it look? • Do you know how to shop for nutritious food on a budget? • Do you know how to make low cost meals that can result in leftovers to freeze or save for another day? • Do you tend to keep all of your clothes clean? • Have you ever had a problem with mice or other bugs like cockroaches as a result of a dirty apartment? • When you have had a place where you have made a meal, do you tend to clean up dishes and the like before they get crusty?

Component	Probing Question(s):
B. Meaningful Daily Activity	• How do you spend your day? • How do your spend your free time? • Does that make you feel happy/fulfilled? • How many days a week would you say you have things to do that make you feel happy/fulfilled? • How much time in a week would you say that you are totally bored? • When you wake up in the morning do you tend to have an idea of what you plan to do that day? • How much time in a week would you say you spend doing stuff to fill up the time rather than doing things that you love? • Are there any things that get in the way of you doing the sorts of activities you would like to be doing?
C. Social Relationships and Networks	• Tell me about your friends, family and the other people in your life. • How often do you get together or chat with these people? • When you go to doctors appointments or meet with other professionals like that, what is that like for you? • Are there any people in your life that you feel are just using you? • Have you ever been threatened with an eviction or lost a place because of something that friends or family did in your apartment? • Are there any of your closer friends that you feel or always asking you for money, smokes, drugs, food or anything like that? • Have you ever had people crash at your place that you did not want staying there? • Have you ever been concerned about not following your lease agreement because of your friends or family?

Component	Probing Question(s):
D. Mental Health and Wellness & Cognitive Functioning	• Have you ever received any help with your mental wellness? • Have you ever had a conversation with a psychiatrist or psychologist? When was that? • Do you feel you are getting all the help you might need with whatever mental health stress you might have in your life? • Have you ever hurt your brain/head? • When you were in school, did you ever have trouble learning or paying attention? Was any reason given to you for that? • Was there ever any special testing done on you when you were in school or as a kid? • Has any doctor ever prescribed you pills for your nerves, anxiety, feeling down or anything like that? • To the best of your knowledge, when your mother was pregnant with you did she do anything that we now know can have lasting effects on the baby? • Have you ever gone to an emergency room or stayed in a hospital because you weren't feeling 100% emotionally?
E. Physical Health and Wellness	• How is your health? • Are you getting any help with your health? How often? • Do you feel you are getting all the care you need for your health? • Anything like diabetes, HIV, Hep C or anything like that going on? • Ever had a doctor tell you that you have problems with your blood pressure or heart or lungs or anything like that? • When was the last time you saw a doctor? What was that for? • Do you have a clinic or doctor that you usually go to? • think would prevent you from living a full, healthy, happy life?

Component	Probing Question(s):
F. Substance Use	• Be straight up - when was the last time you had a drink or used drugs? • Is there anything we should keep in mind related to drugs or alcohol? • [If they disclose use of drugs and/or alcohol] How frequently would you say you use [specific substance] in a week? • In the last little while have you ever drank so much you passed out? • Ever get into fights when you drink? • Ever have a doctor tell you that your health may be at risk in any way when you drink or use drugs? • Ever fall down and bang your head when drinking or using other drugs? • Have you ever used alcohol or other drugs in a way that may be considered less safe? • Do you ever end up doing things you later regret after you have tied one on? • Do you ever drink the likes of mouthwash or cooking wine or hand sanitizer or anything like that? • When you use drugs, in the last year have you ever had bad stuff that made you feel off?
G. Medication	• Do you take any medicines? • [If they do] Were these prescribed by a doctor? To you? • Have you ever sold some or all of your prescription? • Have you ever had a doctor prescribe you a medicine that you didn't have filled at a pharmacy or didn't take? • Were any of your medicines changed in the last month? How did that make you feel? • Do other people ever steal your medicine? • Tell me about how you store your medicine and make sure you take the right medication at the right time each day.

Component	Probing Question(s):
H. Personal A dministration and Money Management	• How are you with taking care of money? • How are you with paying bills on time and taking care of other financial stuff? • Do you have any street debts? • Do you have any drug or gambling debts? • Is there anybody that thinks you owe them money? • Do you budget every single month for every single thing you need? Including cigarettes? Booze? Drugs? • Do you try to pay your rent before paying for anything else? • Are you behind in any payments like child support or student loans or anything like that?
I. Abuse and/or Trauma	• I don't need you to go into any details that you are not comfortable with, but has there been any point in your life where you experience emotional, physical, sexual or psychological abuse? • Are you currently or have you ever receiving professional assistance to address that abuse? • Does the experience of abuse or trauma impact your day to day living in any way? • Does the experience of abuse or trauma impact your ability to hold down a job, maintain housing or engage in meaningful relationships with friends or family? • Have you ever found yourself feeling or acting in a certain way that you think is caused by a history of abuse or trauma? • Is your most recent or any past episodes of homelessness a direct result of experiencing abuse or trauma?
J. Risk of Personal Harm/ Harm to Others	• Do you have thoughts about hurting yourself or anyone else? • Have you ever acted on these thoughts? • When was the last time? • What was occurring when you had these feelings or took these actions? • Have you ever received professional help – including maybe a stay at hospital – as a result of feeling or attempting to hurt yourself or others?

Component	Probing Question(s):
K. Interaction with Emergency Services	• How often do you go to emergency rooms? • How many times have you had the police speak to you over the past six months? • Have you used an ambulance or needed the fire department at any time in the past 6 months? • How many times have you called or visited a crises team or a crisis counsellor in the last 6 months? • How many times have you been admitted to hospital in the last 6 months? How long did you stay?
L. Involvement in High Risk and/or Exploitive Situations	• Does anybody force or trick you to do something that you don't want to do? • Do you ever do stuff that could be considered dangerous like drinking until you pass out outside or delivering drugs for someone or having sex without a condom with a casual partner? • Do you ever find yourself in situations that may be considered at a high risk for violence? • Do you ever sleep outside? Tell me about how you sleep? • Do you have any illnesses that may be passed on to others?
M. Legal	• Got any legal stuff going on? • Have you had a lawyer assigned to you by a court? • [If they do] Got any upcoming court dates? Do you think there's a chance you will do time? • Any involvement with family court or child custody matters? • Any outstanding fines? • Have you paid any fines in the last 12 months for anything? • Have you done any community service in the last 12 months? • Is anybody expecting you to do community service for anything right now? • Did you have any legal stuff in the last year that got dismissed? • Is your housing at risk in any way right now because of legal things?

Component	Probing Question(s):
N. History of Homelessness and Housing	How long have you been homeless? How many times have been homeless in your life other than this most recent time? Have you spent any time sleeping on a friend's couch or floor? And if so, during those times did you consider that to be your permanent address? Have you ever spent time sleeping in a car or alley way or garage or barn or bus shelter or anything like that? Have you ever spent time sleeping in an abandoned building? Were you ever in hospital or jail for a period of time when you didn't have a permanent address to go to when you got out?
O. Managing Tenancy	[For individuals who are housed] Do you think that your housing is at risk? How is your relationship with your neighbours? How have you been doing with taking care of your place?

Building Consistency Using SPDAT

The key to effectively and consistently using the SPDAT within a team and throughout a community is training, practice and sharing successes and mistakes.

Throughout a community of Housing Help, Rapid Re-housing and Housing First professionals, there should be a common understanding about each component of the SPDAT. It is common to most assessment tools for practitioners to have different perspectives about the score of a particular component. The sign of successful, consistent application of the SPDAT is when two people who have experience working with the same client in the same situation have SPDAT scores that vary by only a single point.

Staff members and organizations should not deviate from the current definitions or operational instructions for the SPDAT or create their own system. To ensure valid and reliable evaluation of outcomes, definitions and interpretations of information must be consistent within and across all organizations delivering Housing Help, Rapid Re-housing and Housing First within a community. Doing otherwise results in an inconsistent approach to prioritizing services and meeting the needs of clients. "Creaming" is unacceptable and counter-productive.

Infusing SPDAT into a standard practice will require the tool to be a part of the initial orientation or on-boarding new staff. Shadowing and coaching can be effective approaches for ensuring that new staff members apply the SPDAT consistently with other members of the team.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E info@orgcode.com
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CHS Coordinated Assessment Consumer Survey

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CHS Coordinated Assessment Process Evaluation

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chs
community human services

INTAKE FORM

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IN CASE OF EMERGENCY

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COMMUNITY HUMAN SERVICES CORPORATION
SUPPORTIVE OUTREACH TEAM
Job Description

PAP CODE:
POSITION #:
EEO CLASS:
WC CLASS:

POSITION: Director of Customer Service and Intake
REPORTS TO: CEO

I. FUNCTIONAL DEFINITION

The Director of Customer Service and Intake (DCSI) is responsible for making the application and service experience at CHS a positive one. The DCSI will work with the directors of the Homeless Assistance Programs, the Quality Committee and the CEO to create and operate a seamless and responsive intake protocol that respects the people served by CHS, ensures they receive assistance in a timely manner and oversees client data collection and entry.

The DCSI will recruit, train and supervise the consumer liaisons, data administrators and reception. The DCSI will be responsible for ensuring the entry point services are high functioning, support the work of the programs and deliver excellent customer care.

The DCSI will be responsible for collecting assessments, assisting the intake coordinators in determining program eligibility and program/case manager assignments for all homeless assistance and eviction prevention programs at SOT in conjunction with the program directors. S/he will oversee and assist in the process incoming applications and conduct an initial contact with the applicant to determine eligibility for the appropriate SOT program.

II. RESPONSIBILITIES/ DUTIES

The DCSI will:

1. Support the SOT programs' philosophy and goals.
2. Supervise Customer Service and Intake staff.
3. Identify appropriate procedures for various situations and participate in policy and procedure development with the other Program Directors and CEO.
4. Create a system for and maintain current intake information on all SOT clients.
5. Identify issues and recommend appropriate action to resolve problems.
6. Collaborate with other key community organizations in related areas.
7. Review incoming referrals, determine appropriateness for SOT programs, and assign to a SOT program.
8. Ensure that the Data Administrator receives all needed information for any database and HMIS on each SOT applicant.
9. Administrative oversight to ensure the program is in compliance with all reporting obligations to HUD including all program monitoring visits.
10. Determine appropriate referrals and program linkages.
11. Perform all other duties as assigned.

III. QUALIFICATIONS/ REQUIRED ABILITIES

1. BA/BS degree or any combination of life, work and educational experiences.
2. 3 Year Case Management/ Intake Experience
3. Crisis management skills
4. Supervisory skills
5. Strong organizational, communication and management skills.
6. Ability to manage multiple components of a project in various stages of completion.
7. Sensitivity toward individuals and families in need of program services.
8. Commitment to the project and the agency's mission.
9. Willingness to work collaboratively with staff and other organizations to achieve goals.
10. Advanced computer literacy.
11. A working knowledge of county social service system.
12. The ability to travel independently.

COMMUNITY HUMAN SERVICES CORPORATION
SUPPORTIVE OUTREACH TEAM
Job Description

PAP CODE:
POSITION #:
EEO CLASS:
WC CLASS:

POSITION: Intake Coordinator
REPORTS TO: Director of Customer Service and Intake

I. FUNCTIONAL DEFINITION

The Intake Coordinator will work in conjunction with the Program Director to ensure efficient assessment and program assignment procedures for all of the SOT's Homeless Assistance Programs. The focus of these programs is to create a continuum of care of homeless services to be provided to persons who are homeless, at risk of being homeless or experiencing other housing instability. The programs seek to empower consumers to secure and/or maintain permanent housing.

The Intake Coordinator is responsible for performing assessment and program/case manager assignments for all homeless assistance and eviction prevention programs at SOT. S/he will process incoming applications and conduct an initial contact with the applicant to determine eligibility for the appropriate SOT program. S/he will input data on each client into the electronic records data base to ensure client information can be tracked. S/he will act as the initial point of contact for all clients and respond to issues around their assignment into a SOT program until connected with the assigned case manager.

II. RESPONSIBILITIES/ DUTIES

The Intake Coordinator will:

1. Support the SOT programs' philosophy and goals.
2. Identify appropriate procedures for various situations and participate in policy and procedure development with the Program Director.
3. Maintain current intake information on all SOT clients.
4. Identify issues and recommend appropriate action to resolve problems.
5. Collaborate with other key community organizations in related areas.
6. Review incoming referrals, contact applicants, determine appropriateness for SOT programs, and assign to a SOT program with a case manager.
7. Ensure that the Data Administrator receives all needed information for any database and HMIS on each SOT applicant.
8. Administrative oversight to ensure the program is in compliance with all reporting obligations to HUD including all program monitoring visits.
9. Determine appropriate referrals and program linkages.
10. Perform all other duties as assigned.

III. QUALIFICATIONS/ REQUIRED ABILITIES

1. BA/BS degree or any combination of life, work and educational experiences.
2. 1 Year Case Management Experience
3. Strong organizational, communication and management skills.
4. Ability to manage multiple components of a project in various stages of completion.
5. Sensitivity toward individuals and families in need of program services.
6. Commitment to the project and the agency's mission.
7. Willingness to work collaboratively with staff and other organizations to achieve goals.
8. Basic computer literacy.
9. A working knowledge of county social service system.
10. The ability to travel independently.

COMMUNITY HUMAN SERVICES
SUPPORTIVE OUTREACH TEAM
Job Description

PAP CODE: SA-1
POSITION NO: 903
EEOC CLASS: 951
WC CLASS: 2

POSITION: Consumer Liaison
REPORTS TO: Director of Customer Service and Intake

I. FUNCTIONAL DEFINITION:

The Consumer Liaison will be the first service connection for families and individuals who will be participating in HUD and HAP housing programs. The focus of the projects is the creation of a service environment that fosters greater independence and the ability to bridge the gap from unstable or temporary housing to safe and affordable permanent housing.

The Consumer Liaison will be assisting the team with the intake and referral process, including but not limited to, making the first contact with potential participants, identifying appropriate services and making intra and interagency referrals. The Consumer Liaison is under the general supervision of the Director of Customer Service and Intake.

II. RESPONSIBILITIES / DUTIES:

The Consumer Liaison will be responsible for incoming calls to the Supportive Outreach Team offices and in that capacity will be the first point of contact with current and/or potential program participants.
The Consumer Liaison will:

1. Answer incoming calls to the Supportive Outreach Team office.
2. Gather all pertinent information surrounding individual/family needs.
3. Link individuals/families with any appropriate services offered by the Supportive Outreach Team as well as any other appropriate Community Human Services programs.
4. Provide referrals to individuals/families who are not appropriate for or are seeking services that are unavailable through Community Human Services.
5. Diplomatically handle difficult and demanding calls from potential and/or current program participants and use independent judgment to determine how calls are to be processed.
6. All other duties assigned.

III. QUALIFICATIONS / REQUIRED ABILITIES:

1. A working knowledge of the social service system through life or job related experience.
2. A willingness to work collaboratively in a team setting.
3. Excellent communication and interpersonal skills.
4. Strong organizational, phone and computer skills.
5. Ability to work and travel independently.
6. Must have a valid PA driver's license.

Employee Name: _____

Employee Signature: _____

Date: _____

COMMUNITY HUMAN SERVICES
SUPPORTIVE OUTREACH TEAM
Job Description

PAP CODE: S-4
POSITION NO: 034
EEOC CLASS: 2
WC CLASS: 951

POSITION: Receptionist
REPORTS TO: Director of Customer Service and Intake

I. FUNCTIONAL DEFINITION:

The Receptionist will be the first service connection for walk-in families and individuals coming in to apply for Homeless Assistance Programs and other services offered or for scheduled appointments. The focus of the project is the creation of a service environment that fosters greater autonomy, coordinated care and the ability of participants to bridge the gap from homelessness or near homelessness to safe, affordable permanent housing.

The Receptionist will be responsible for maintaining and promoting hospitality at all times by welcoming, serving and assisting all consumers. The receptionist must always be able to maintain professional boundaries while remaining polite yet firm when dealing with difficult, impatient and/or emotionally distraught customers.

The Receptionist is under the general supervision of the Director of Customer Service and Intake.

II. RESPONSIBILITIES / DUTIES:

The Receptionist will be responsible for greeting all walk-in consumers visiting the Supportive Outreach Team office and in that capacity will be the first point of face-to-face contact with current and/or potential program participants. The Receptionist will also:

1. Check an Excel-based "appointment log" for scheduled appointments, escort visitors to the waiting area and notify the appropriate staff of their arrival.
2. Distributing/ reviewing and assisting consumers with the completion of the application then collecting them to turn over to the Data Administrator.
3. Photocopying, filing and shredding confidential supportive documents as necessary.
4. Monitoring the waiting area and maintaining its resource walls.
5. Provide resources to individuals/ families who are not appropriate for or are seeking services that are unavailable through Community Human Services.
6. Diplomatically handle difficult and demanding potential and/ or current program participants and use independent, good judgment to determine what steps are necessary and what staff, if any, should be contacted.
7. Attend meetings/ trainings to enhance skills and working knowledge to better serve SOT consumers.
8. All other duties as assigned.

III. QUALIFICATIONS / REQUIRED ABILITIES:

1. Excellent communication and interpersonal skills.
2. Strong organizational, phone and computer skills.
3. A working knowledge of the social service system through life or job related experience.
4. A willingness to work collaboratively in a team setting, yet have the ability to work independently.
5. Strong ability to navigate the World Wide Web to familiarize and access various resources.

Employee Name: _____

Employee Signature: _____

Date: _____

Adrienne Walnoha

[redacted]

OBJECTIVE:

To steward the work of Community Human Services Corporation utilizing holistic approaches in order to provide comprehensive service to individuals, families and communities.

ACADEMIC BACKGROUND AND HONORS:

- Masters of Social Work – University of Pittsburgh (Graduation Dec 1999)
- Commonwealth of PA Licensure for Social Workers #SW-012738-L
- Political Science Masters Program – University of Pittsburgh (1994-1995)
- Bachelor of Arts in Political Science – Chatham College (1994)
  Graduation with Honors – Magna Cum Laude
- Finance and Investing Certificate – American Mgmt & Business Admin Institute
- Phi Beta Kappa (Inducted 1994)
- Chatham Alumnae Award (Received 1994)
- Social Work Alumnae Award (Received 2011)
- National Psychology Honors Organization (Inducted 1993)
- Leadership Development Initiative (Class XIV: 2006-2007)
- Pittsburgh's 40 Under 40: Individuals under 40 Shaping the Region

SPECIAL SKILLS:

- Proficient in Microsoft Office Applications
- Planning and execution of needs assessments
- Conducting focus groups
- Grant writing
- Program development/ assessment: planning, policies, execution and evaluation
- Public speaking

FACULTY EXPERIENCE:

- Adjunct Faculty Member: CCAC (March 2003 - Present), University of Pgh (Jan 2007 – Present)
- Provider Trainings: Act 148, Confidentiality, Professionalism and Boundaries, Documentation and Record Keeping
- Adjunct Faculty and Field Placement Instructor University of Pittsburgh
- Lecturer Chatham College
- Appointee to special committee on academic programming at University of Pittsburgh School of Social Work- Community Organizing and Social Administration and Direct Practice
- Dean of University of Pittsburgh School Social Work Executive Council
- Co Investigator – *Utilization of Principles of Community-Based Participator Research (CBPR) and Concept Mapping to Foster and Inform Community Engaged Research*
- Servant Leadership Experience- Belfast and Dublin for University of Pittsburgh 2011

LECTURES AND PUBLICATIONS:

- *Developing a Tailored Physical Activity Program for People with Severe and Persistent Mental Illness in the Community*. Submitted, August 2013.

- *Creating Synergies: Partnerships for Participatory Evaluating in Human Services (Chapter)*. Community Development in the Steel City: Democracy, Justice, and Power in Pittsburgh. Community Development Journal, September 2012.
- *Translating Community-Based Participatory Research (CBPR) Principles into Practice*. Progress in Community Health Partnerships: Research, Education, and Action; In Press, Fall 2013.
- *Translating Community-Based Participatory Research (CBPR) Principles into Practice: Building a Research Agenda to Reduce Intimate Partner Violence*. Submitted, Fall 2011.
- *Utilization of Principles of Community-Based Participator Research (CBPR) and Concept Mapping to Foster and Inform Community Engaged Research*.
- Community and Campus Partnerships for Health and Wellness Fall 2011 Plenary Session-University of Pittsburgh
- *Using community based participatory research to develop a depression-care model for disadvantaged low-income persons* in Psychiatric Services March 2010
- Photo Voice Workshop (March 2010) at ONTRACK with Recovery Conference
- *Social Workers Respond in Today's Economic Crisis* (March 2010) at PA Southwest Division Social Work Month Forum
- Key Note Address (March 2010) at the SPRING Service Learning Network, Transforming Institutions, Transforming Communities
- *Understanding the Community from the Community*- Co Presenter (May 2010) at ONE: Pittsburgh
- *Creating University-Community Partnerships: Campus Compact* (April 2011) at PA Campus Compact

OCCUPATIONAL HISTORY:

Chief Executive Officer (December 2006 – Present) Community Human Services Corporation, Pittsburgh PA

- Organizational planning and operations
- Supervision of Program Directors and Controller
- Financial management
- Fund development
- Program Development
- Organizational change management
- Community organizing

Interim Executive Director (December 2005 – December 2006) Community Human Services Corporation, Pittsburgh PA

- Temporarily perform all assigned duties upon resignation of the Executive Director including direct supervision of nine additional staff, oversight of the fiscal department and the Lawn Street Center

Director of Homeless Assistance Programs (January 2004-January 2007) Community Human Services Corporation (CHSC), Pittsburgh PA

- Supervision of 15 staff
- Administrative oversight of three homeless assistance programs
- Fund identification and grant writing to support the programs
- Administration of Severe Weather Emergency Shelter
- Administration of Families United Program
- Consolidation and expansion of the following Team Leader responsibilities

Supportive Outreach Team Leader (January 2002-January 2004) CHSC

- Supervise eleven team members
- Monitor and administer HUD, HAP, PATH funded programs
- Pursue new and expanded funding opportunities
- Ensure procedural and fiscal requirements are met for each funding stream
- Develop new and expanded homeless outreach and housing programs

Transitional Housing Program Team Leader (July 2001-Present) CHSC
- Supervise five team members
- Monitor and administer program
- Restructure program to ensure longevity after current funding is exhausted
- Ensure HUD's fiscal and procedural requirements are met
- Develop therapeutic support groups for program participants

Housing Specialist (May 1999-July 2001) Southwestern Pennsylvania AIDS Planning Coalition, Pittsburgh PA
- Conduct countywide HIV/AIDS housing needs assessments
- Arrange focus groups and key informant interviews
- Analyze survey data and draft housing plans
- Provide technical assistance to human service providers for housing projects
- Identify special population housing needs and provide trainings to housing providers to address those needs

Mobile Therapist (December 1999-Present) Youth Advocate Program, Pittsburgh PA
- Therapeutic intervention with youth and families in the home and community
- Conduct clinical assessments
- Draft treatment plans and engage youth and families in goal setting

Therapeutic Staff Support (September 1999-December 1999) Youth Advocate Program
- Provide emotional, social and behavioral support to adolescents
- Facilitate therapeutic support skills in families, educators, and the community

Intern Case Manager (September 1998-May 1999) Pittsburgh AIDS Task Force, Pittsburgh PA
- Research for resource manual dedicated to services for HIV+ individuals
- Daily case management including budgeting, life skills, med management, resource coordination and supportive counseling
- Client Advocacy

Exhibition Staff Manager (March 1998-March 2000) Pittsburgh Filmmakers, Pittsburgh PA
- Supervise four staff members for nightly theater exhibitions
- Perform general book keeping and clerical duties
- Take inventory and place orders

Individual Care Provider (1993-1999) Pittsburgh Area Youths, Pittsburgh PA
- Provide daily developmental, emotional and educational support for youths (age 4-15)

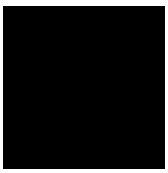
PROFESSIONAL COMMITTEES:

Allegheny Cty Local Housing Option Team
HEARTH Work Group
FEMA Board
WPAPC Housing Services Delivery Committee
Food Security Partnership
Department of Human Services Advisory

Homeless Advisory Board
Conference of Allegheny Providers
Oakland Business Improvement District Board
Affordable Care Act Advisory Team
Neighborhood Partners Program
Oakland Task Force

REFERENCES:

Doug Clewett, Community Human Services
Barb Feige, ACLU
Michael Yonas, Department of Human Services
Al Condeluci, UCP
Tracy Soska, University of Pittsburgh



Natalie M. Ryan
[redacted]

EDUCATION

University of Pittsburgh Pittsburgh, Pennsylvania

- Earned a Masters Degree in Social Work from the University of Pittsburgh in April 2008
- Received the School of Social Work Community Practice Award for excellence in community organizing at the HI HOPE resource center in Hazelwood
- Obtained the Family Development Credential (FDC) training through Allegheny County Office of Behavioral Health in May 2009
- Earned a Bachelor of Science in Psychology in April 2002
- Obtained a License in Social Work in the state of Pennsylvania, License #SW127996

EMPLOYMENT

2008-2014 Community Human Services
Supportive Service Coordinator, Families United Program

- Coordinate all aspects of the Families United Program, a Housing and Urban Development (HUD) funded permanent housing program that bridges the gap from homelessness to permanent housing
- Independently counsel participants in identifying and working through personal issues
- Link caseload of 25 participants to appropriate referrals for counseling, crisis intervention, and life planning
- Address complaints, incident reports, and challenging behaviors with clients to ensure that their housing is stable
- Encourage participants to maintain a secure living environment so that they may reach their goals and ultimately become independent
- Utilize a strengths based approach to goal planning and assist participants with strategies to reach those goals
- Serve as a Field Instructor to University of Pittsburgh Master of Social Work and Bachelor of Social Work students since 2010.

2008-2010 Allegheny Psychological Services
Mobile Therapist

- Develop mental health interventions appropriate for youth and adolescents in the community
- Provide individual and family therapy with clients in their homes
- Develop care plans based on the needs of individual clients
- Supervise TSS staff assigned to cases
- Participate in interdisciplinary team meetings to ensure collaboration between agencies

2006-2008 Community Human Services

Intern, Supportive Outreach Team and HI HOPE resource center

- Develop and organize a guide for Pittsburgh social service resources to be used throughout Community Human Services Corporation
- Organize donations for the agency and distribute appropriately to clients
- Utilize the Benefit Bank technology to assist clients in accessing benefits

2004-2007 Western Psychiatric Institute and Clinic

Case Manager, Services and Research for the Recovery of the Seriously Mentally Ill

- Provide quality care to a caseload of 30 severely mentally ill individuals
- Earned the Western Psychiatric Institute and Clinic's Making a Difference Award for outstanding case management skills in August, 2006
- Provide advocacy for mental health consumers while teaching independence and self-reliance
- Complete all documentation within specific timeframes as regulated by both state, county, and internal guidelines
- Work independently to meet productivity guidelines for caseload with minimal supervision
- Develop strength-based service plans for consumers that help them identify the areas in their life that need assistance and follow through

LauraEllen Ashcraft, MSW

[redacted]

Education:

Master of Social Work, *School of Social Work*, University of Pittsburgh, GPA 3.9 December 2013
Concentrations: *community organization and social administration*
Certificate, Human Service Management

Bachelor of Arts, *Social Work,* Millersville University of Pennsylvania, GPA 3.5 May 2012
minor: *Spanish*
Phi Alpha, Theta Alpha Chapter; January 2011-Present

Professional Experience:

Non-profit Consulting; Pittsburgh, PA January 2013 - Present
- Executed the restructuring of homeless services intake process and corresponding evaluations
- Catalyst for development of central intake for multi-program agency including analyzing over 1,500 pieces of data
- Guided strategic planning process for food pantry serving over 1,000 people a month
- Led consumer satisfaction surveys for drop-in center for the past three years' contract renewal process

Social Welfare and the Law, Millersville University of Pennsylvania, Millersville, PA March 25, 2014
Guest Lecturer
- Presented "Legislative Advocacy" to three undergraduate social work classes
- Combined best practices and personal experience in how to talk with elected officials
- Recommended techniques to successfully advocate for human services

DHS Speaker Series, Allegheny County Department of Human Services, Pittsburgh, PA
Presenter September 25, 2013
- Presented "Primary Health Care in Cuba, a Model of System Integration" to forty DHS employees
- Analyzed health care and human service system in Cuba
- Recommended integration techniques for improving service delivery

Bridging the Gaps, Pittsburgh, PA June 2013 - July 2013
Community Health Intern, Gay and Lesbian Community Center:
- Empowered self-expression of 100 LGBTQIA youth through creative qualitative data collection
- Created resource guide for youth, staff, and volunteers of over 75 community services

Allegheny County Department of Human Services; Pittsburgh, PA August 2012 - April 2013
Quality Improvement Intern, Office of Data Analysis, Research and Evaluation
- Co-author of 2012 Allegheny County Child Fatality/Near Fatality Report
- Summarized over 300 pieces of Pennsylvania legislation and analyze effect on DHS
- Performed qualitative case reviews to support state-mandated Child Fatality and Near Fatality Review process
- Analyzed over 200 pieces of child abuse legislation in Pennsylvania and made recommendations to improve policy and practice across child and family- serving systems
- Staffed Permanency Roundtable process funded by Casey Family Programs
- Assisted in local site agency implementation of annual PA DPW Office of Children, Youth and Families Quality Service Review process

Lancaster County Behavioral Health and Disability Services; Lancaster, PA May 2011 - May 2012
Administrative Department Intern
- Collaborated with over forty community leaders, elected officials, and homeless services providers to advance ten year plan to end homelessness
- Coordinated submission process for $30 million grant to US Health and Human Services, Centers for Medicare & Medicaid
- Organized fifty volunteers to conduct US Housing and Urban Development (or federal HUD) Point in Time count of people experiencing homelessness
- Analyzed Pennsylvania Human Service Development Fund Block Grant and projected effect on Lancaster County's $124 million budget

Research:

Honors Thesis, Millersville University of Pennsylvania, Millersville, PA May 2011 - May 2012
Principal Investigator

- Analyzed self-esteem in adults with mental illnesses
- First Social Work major to receive departmental honors
- Successfully competed for Student Research Grant funding

Self-Esteem in an Adult with Mental Illness: A single-subject research design Spring 2011
Millersville University of Pennsylvania, Millersville, PA
Principal Investigator

- Analyzed self-esteem in an adult with a mental illness as affected by a progressive nine module intervention
- Presented Research at 2011 Conference; National Association of Social Workers-Pennsylvania Chapter; October 13-15,2011 & Pennsylvania Association of Undergraduate Social Work Education; April 8-9, 2011

Community Leadership:

National Association of Social Workers 2011- Present
Member, Pennsylvania Chapter

- Legislative Advocacy Day, 2011, 2012, and 2014
- Coordinated participation for Southwest Division in Legislative Advocacy Day 2014
- Coordinated volunteers for 2014 Southwest Division Conference

University of Pittsburgh, School of Social Work, Pittsburgh, PA December 2012 - December 2013
President, Student Executive Committee

- Represent over 400 students in the Master's of Social Work program to School faculty and staff
- Provide oversight to budget of over $14,000 annually
- Review and approve over $3,000 of student conference and travel grants annually

Social Work Organization; Millersville, Pa September 2011-May 2011
President

- Doubled membership participation in bi-weekly meetings and activities
- Increased fundraising and events benefiting local organizations by 200%
- Lead participation of over 100 students in legislative advocacy with NASW-PA in Harrisburg, PA

International Experience:

Center for Race and Social Problems; Havana, Cuba March 8-17, 2013
Student

- Met with more than ten different human service providers
- Researched race, health disparities, and the primary care system in Cuba

Kairos Ministries; Guatemala City, Guatemala July 16-24, 2011 and July 16-24, 2010
Translator

- Provided translation for doctors, nurses, and other non-medical personnel
- Assisted in providing medical services for indigenous populations

Iglesia Menonita de Choele Choel; Rio Negro, Argentina July 2006 and July 2008
Student

- Provided translation services for 20 high school students
- Lived with Argentine family, learned language, and culture

Honors and Awards:

Millersville University of Pennsylvania, Millersville, PA,

Social Work Organization Award	March 2012
Millersville University Junior Leader of the Year	April 10, 2011
Carnegie Community Engagement Classification	March 23, 2011